Preventing violence

A guide to implementing the recommendations of the *World report on violence and health*

WORLD HEALTH ORGANIZATION
GENEVA

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Box sources

- Box 1, adapted from *World report on violence and health* [1]
- Box 2, Irvin Waller, Department of Criminology, University of Ottawa, Canada
- Box 3, Elizabeth Ward, Ministry of Health, Jamaica
- Box 4, adapted from *World report on violence and health*
- Box 5, Brett Bowman and Mohamed Seedat, Institute for Social and Health Sciences, University of South Africa, South Africa
- Box 6, from Waters H, et al.[2]

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Foreword

Interpersonal violence is violence between individuals or small groups of individuals. It is an insidious and frequently deadly social problem and includes child maltreatment, youth violence, intimate partner violence, sexual violence and elder abuse. It takes place in the home, on the streets and in other public settings, in the workplace, and in institutions such as schools, hospitals and residential care facilities. The direct and indirect financial costs of such violence are staggering, as are the social and human costs that cause untold damage to the economic and social fabric of communities.

With the publication in 2002 of the *World report on violence and health*, an initial sense of the global extent of the interpersonal violence problem was provided, and the central yet frequently overlooked role of the health sector in preventing such violence and treating its victims was made explicit. The report clearly showed that investing in multi-sectoral strategies for the prevention of interpersonal violence is not only a moral imperative but also makes sound scientific, economic, political and social sense, and that health sector leadership is both appropriate and essential given the clear public health dimensions of the problem and its solutions. The report also reviewed the increasing evidence that primary prevention efforts which target the root causes and situational determinants of interpersonal violence are both effective and cost-effective. In support of such approaches, the report recommended six country-level activities, namely:

1. Increasing the capacity for collecting data on violence.
2. Researching violence – its causes, consequences and prevention.
3. Promoting the primary prevention of violence.
4. Promoting gender and social equality and equity to prevent violence.
5. Strengthening care and support services for victims.
6. Bringing it all together – developing a national action plan of action.

In the 18 months following the launch of the *World report on violence and health*, resolutions urging governments to implement its recommendations were adopted by the World Health Assembly, the African Union and the Human Rights Commission, while the World Medical Association issued a Statement on Violence and Health calling on national medical associations to provide training and advocate for violence prevention along the lines of the report recommendations. During almost 50 national launches of the report, health ministers convened partners from other government departments (such as justice, education and welfare), from nongovernmental organizations (NGOs) and from the research community to discuss implementing its recommendations within their countries. Other United Nations agencies were made aware of the report, and a number of donor countries and foundations agreed to form an alliance aimed at strengthening policy and programme support for national- and community-level projects built around the report recommendations.

One outcome of these efforts to raise awareness of the report and increase political commitment to implementing its recommendations was a surge in requests from national governments, international agencies, NGOs and foundations for guidelines in this area. This document, *Preventing violence*, has been prepared by WHO's Department of Injuries and Violence Prevention, in consultation with violence prevention experts from around

the world, as a first response to these requests, and provides conceptual, policy and practical advice on how to implement each of the six country-level activities.

Parts 1–6 of the current work correspond to the above recommendations and outline both the core components of a comprehensive approach to interpersonal violence prevention and the broader issue of bringing together these and other components in the form of a national-level action plan involving multiple sectors. Each of the six parts is sub-divided into the following three areas:

- **Conceptual Aspects** concerning the general principles that must be considered in implementing each recommendation.
- **Policy Issues** covering the relationship of each recommendation to policy instruments and policy-development processes within the health sector and in other sectors; the use of existing policies; and the creation of new policies to promote enhanced prevention and victim services and support.
- **Action Steps** providing practical suggestions on how to advance implementation of each of the specific recommendations, and where possible providing checklists and templates for evaluating country-level work against guideline recommendations.

References are also provided throughout to electronic and printed versions of existing resource materials, such as guidelines for the surveillance of violence and injuries, information on where to find best-practice examples for primary prevention programmes, and guidelines for the provision of victim care and support services.

Finally, the **Action Steps** when considered together provide a template for a comprehensive national plan of action, and these have been summarized in the **ANNEX**. The development and implementation of such a plan can make a major contribution to establishing violence prevention programmes and setting in place the societal conditions that can lead to significant reductions in the levels of interpersonal violence and improved services for those affected. Moreover, such a plan sends the clear message that the human, social and economic costs of interpersonal violence can be avoided and should no longer be accepted.

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Introduction

Interpersonal violence – its nature, magnitude and consequences

What is "interpersonal violence"?

Interpersonal violence is one of the three major categories of violence identified by the *World report on violence and health* (**BOX ONE**). The range of contexts in which it occurs is enormous, and includes child abuse and neglect by parents and caregivers; violence between adolescents and young adults; violence between intimate partners; violence associated with property crimes; rape and other sexual violence; workplace violence; and the abuse of the elderly by relatives and other caregivers. Such violence between individuals happens every minute of every day, and in one form or another affects everyone.

BOX ONE

Definition and types of violence

This guide follows the definition of violence put forward in the *World report on violence and health* namely:

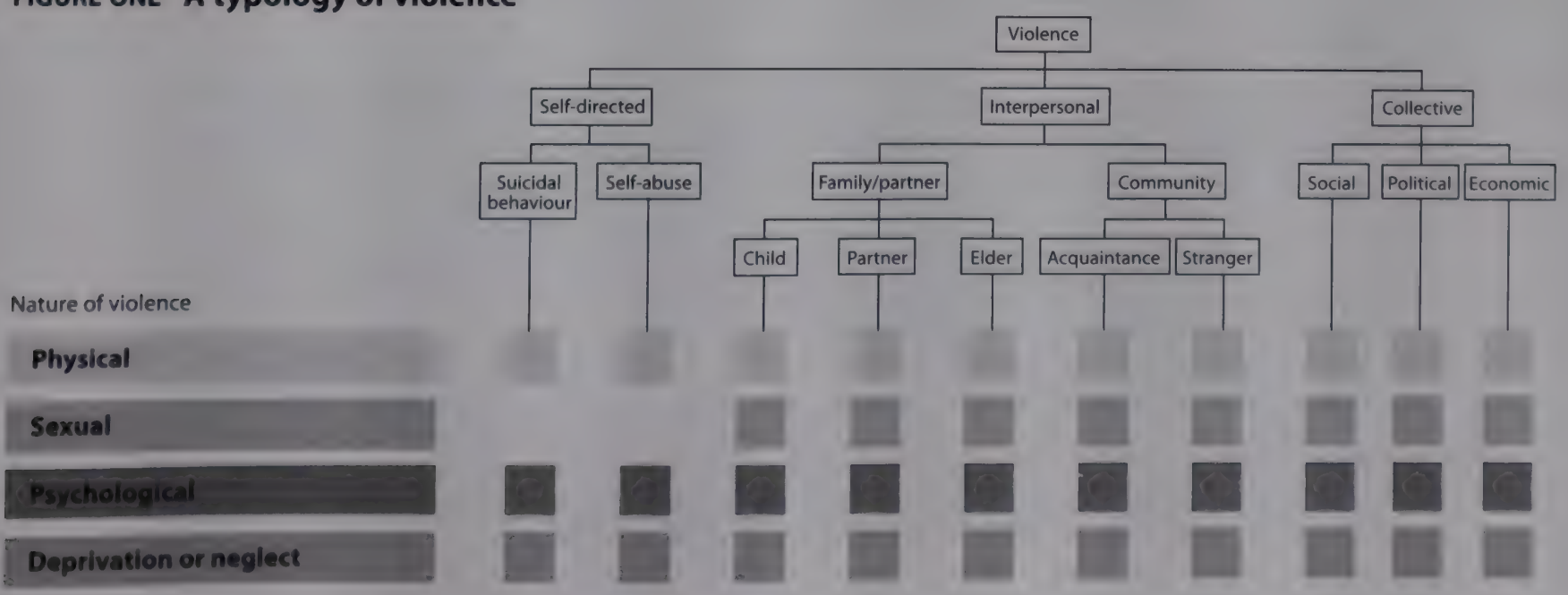
> *the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation.*
>
> CHAPTER 1 *VIOLENCE – A GLOBAL PUBLIC HEALTH PROBLEM*, PAGE 5

Within this general definition, the report further divides violence into three sub-types according to the context in which it is committed.

- **Self-directed violence** refers to violence in which the perpetrator and the victim are the same individual and is subdivided into self-abuse and suicide.
- **Interpersonal violence** refers to violence between individuals, and is subdivided into "family and intimate partner violence" and "community violence". The former category includes child maltreatment; intimate partner violence; and elder abuse, while community violence is broken down into acquaintance and stranger violence and includes youth violence; assault by strangers; violence related to property crimes; and violence in workplaces and other institutions.
- **Collective violence** refers to violence committed by larger groups of individuals and can be subdivided into social, political and economic violence.

Cross-cutting each of these categories are the four modes in which violence may be inflicted, namely: physical; sexual; and psychological attack; and deprivation. Although not universally accepted, the classification of violence according to its type and mode of occurrence shown in **FIGURE ONE** provides a useful framework for understanding the often complex patterns of violence.

FIGURE ONE A typology of violence



How big is the problem of interpersonal violence?

Globally, around 520 000 people die each year as a result of interpersonal violence. That means approximately 1400 deaths every day – the equivalent of three long-haul commercial aircraft crashing every single day, week in and week out, year after year.

Most victims[1] and perpetrators of interpersonal violence are between 15 and 44 years old. Because it so frequently occurs among adolescents and young adults, very high rates of interpersonal violence in societies and communities can effectively cancel out many of the health gains achieved through infant and child-health programmes.

There are, however, major variations in the incidence of fatal interpersonal violence between different regions of the world and between men, women and children. In all regions male homicide rates are considerably higher than female homicide rates, although this male-female difference tends to be lower in regions with lower overall homicide rates. Homicide rates are higher in countries with high levels of income inequality and among the residents of poorer households.

But deaths are only the tip of the interpersonal violence iceberg. For every death due to interpersonal violence there are perhaps hundreds more victims that survive. Globally, tens of millions of children are abused and neglected each year; up to 10% of males and 20% of females report having been sexually abused as children. For every homicide among young people there are 20–40 non-fatal cases which require hospital care. In addition, rape and domestic violence account for 5–16% of healthy years of life lost by women of reproductive age, and, depending on the studies, 10–50% of women experience physical violence at the hands of an intimate partner during their lifetime.

What is the economic cost of interpersonal violence?

Interpersonal violence is expensive. A recent review[2] estimates that the costs of interpersonal violence in the United States of America (USA) reach 3.3% of the gross domestic product. In England and Wales, the total costs from violence – including homicide, wounding and sexual assault – amount to an estimated US$ 40.2 billion annually. Evidence abounds that the public sector – and therefore society in general – pays the bulk of these costs. For example, in the USA 56–80% of the costs of care for gunshot and stabbing injuries are either directly paid by public financing or are not paid at all. In the latter case, they are absorbed by government and society in the form of uncompensated care financing and overall higher payment rates of personal income tax. In low and middle-income countries, too, it is likely that society absorbs much of the costs of violence, through direct public expenditures and negative effects on investment and economic growth.

The purpose, scope and target audience of this guide

Purpose

This guide complements both the *World report on violence and health* and the 2003 World Health Assembly resolution 56.4 on implementing its nine recommendations, which were to:

1. Create, implement and monitor a national action plan for violence prevention.
2. Enhance capacity for collecting data on violence.

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[1] The use of the term "victim" to describe an individual who has been subjected to violence and its consequences (or to any negative health outcome) is the subject of an ongoing debate concerning the degree to which such terms are disempowering in themselves. The use of this term in the current document is intended to reflect the full scope of the effects of victimization, from mild short-term effects, through severe and chronic disability, to death. No implications relating to issues such as personal resilience are intended or should be assumed.

[2] All references are available upon request.

3. Define priorities for, and support research on, the causes, consequences, costs and prevention of violence.
4. Promote primary prevention responses.
5. Strengthen responses for victims of violence.
6. Integrate violence prevention into social and educational policies, and thereby promote gender and social equality.
7. Increase collaboration and exchange of information on violence prevention.
8. Promote and monitor adherence to international treaties, laws and other mechanisms to protect human rights.
9. Seek practical, internationally agreed responses to the global drugs trade and the global arms trade.

This guide discusses in detail – and suggests **Action Steps** for addressing – the first six of these recommendations. Such guidance will help fill the gaps in awareness that prevention works and knowledge of how to do it that persist despite increasing evidence that violence prevention measures are both effective and cost-effective. These gaps exist in all countries, and especially in many of the developing and transitional countries that stand to lose the most from high levels of interpersonal violence and that have the most to gain from the urgent implementation of systematic prevention strategies.

By following the **Action Steps** in each part of this guide, health planners and representatives of other sectors should be able to initiate activities that will lead to the development of national and municipal-level programmes to address one or more of the *World report on violence and health* recommendations covered by these guidelines. The nature of these activities will depend upon the stage of development and maturity of existing violence prevention activities. In settings where violence prevention has yet to begin, activities might be limited to preparing a national plan of action as a basis for requesting assistance in its implementation. In another setting where, for instance, information systems are well developed but primary prevention has yet to be significantly promoted, activities might focus upon moving from data to action and the development of violence prevention policy.

Scope

In addition to its specific component parts, four overarching themes distinguish the approach adopted in this guide:

- It deals with interpersonal violence *as a whole*.
- It uses an *ecological model* to help understand the causes, consequences and prevention of interpersonal violence.
- It promotes a *public health approach* for multi-sectoral prevention activities.
- It addresses *violence prevention* as distinct from *crime prevention*.

Dealing with interpersonal violence as a whole

This guide aims to assist in the prevention of interpersonal violence as a whole, rather than focusing on individual sub-types of interpersonal violence such as child maltreatment; intimate partner violence; sexual violence; youth violence; or elder abuse. Specialized prevention efforts that focus on a single sub-type of interpersonal violence are becoming more common; yet evidence is increasing that underlying the different sub-types is a set of common causes and cross-cutting risk factors. In addition, the people affected by its different sub-types often have shared needs in respect of medical, psychological and social welfare services. It is therefore proposed that by dealing with interpersonal violence as a whole and addressing these common causes and factors, all forms of interpersonal violence will be reduced.

An ecological perspective

This guide follows the *World report on violence and health* in adopting an ecological model for understanding the causes, consequences and prevention of violence (**FIGURE TWO**). The ecological model is based on evidence that no single factor can explain why some people or groups are at higher risk of interpersonal violence while others are more protected from it. Instead, the model views interpersonal violence as the outcome of interaction among many factors at four levels: the individual, the relationship, the community and the societal. In this model the interaction between factors at the different levels is just as important as the influence of factors within a single level. For example, longitudinal studies suggest that complications associated with pregnancy and delivery (that is, individual risk factors that may lead to neurological damage and psychological or personality disorder) seem to predict violence during youth and young adulthood mainly when they occur in combination with other problems within the family (a close relationship factor) such as poor parenting practices.

FIGURE TWO Ecological model showing shared risk factors for sub-types of interpersonal violence

As noted above, among the many risk factors for the different types of interpersonal violence, some are common to most sub-types, and therefore are the focus of attention in this guide. **FIGURE TWO** lists a number of these cross-cutting risk factors at each of the four levels of the ecological model.

a) At the individual level, personal history and biological factors influence how individuals behave and their likelihood of becoming a victim or a perpetrator of violence. Among these factors are being a victim of child maltreatment, psychological or personality disorders, alcohol and/or substance abuse, and a history of behaving aggressively or having experienced abuse.
b) Personal relationships such as those with family, friends, intimate partners and peers may also influence the risks of becoming a victim or perpetrator of violence. For

example, a poor relationship with a parent and having violent friends may influence whether a young person engages in or becomes a victim of violence.

c) Community contexts in which social relationships occur (such as schools, neighbourhoods and workplaces) also influence the likelihood of violence. Risk factors here may include the level of unemployment, population density and mobility, and the existence of a local drug or gun trade.

d) Societal factors influence whether violence is encouraged or inhibited. These include economic and social policies that maintain socioeconomic inequalities between people, the availability of weapons, and social and cultural norms such as those relating to male dominance over females, parental dominance over children, and cultural norms that endorse violence as an acceptable method to resolve conflicts.

The ecological model is also useful to identify and cluster intervention strategies at the four different levels. **Part 3** of this guide discusses ways of promoting the primary prevention of interpersonal violence, and describes a number of proven and promising interventions at each of the four ecological levels.

Promoting a public health approach

This guide describes a public health approach to the prevention of interpersonal violence. Such an approach requires the involvement of many sectors and disciplines both to prevent violence from occurring in the first place and to extend better care and safety to affected populations. The health sector, however, is the natural leader as it is explicitly designed to define, understand, and address population-wide health challenges, and at the societal level it is the health sector that carries the major burden of care arising from the consequences of violence. The health sector is also likely to have experience with building the kinds of multi-sectoral partnerships that are necessary for the prevention of violence and the mitigation of its consequences.

By definition, public health aims to provide the maximum benefit for the largest number of people. In practice a public health approach to the prevention of interpersonal violence involves four distinct steps. The first step is to define the magnitude, scope, characteristics and consequences of such violence through the systematic collection of information. The second step is to identify and research the risk and protective factors that increase or decrease the likelihood of violence, including those that can be modified through interventions. The third step is to determine what works in preventing violence by developing and evaluating interventions tailored to the demographic and socioeconomic characteristics of the groups in which they are to be implemented. The fourth step is to implement effective and promising interventions in a wide range of settings and, through ongoing monitoring of their effects on the risk factors and the target problem, to evaluate their impact and cost-effectiveness.

Violence prevention and crime prevention

A criminal justice approach to preventing violence attempts to deter potentially violent behaviour at the individual level with the threat of punishment for violent acts. It answers the questions, "how do we attain justice?" and "how much punishment does this criminal deserve?". While such an approach is present to varying degrees in almost every country, and may be effective at the individual level to deter violent behaviour, it is not sufficient for the primary prevention of interpersonal violence and the mitigation of its consequences at the population level. Many crimes have nothing at all to do with violence, and, while most forms of violence are also criminal offences, much interpersonal violence does not come to the attention of the criminal justice system even in high-income countries.

The public health approach seeks to supplement deterrence-oriented criminal justice by answering the questions, "who are the victims and perpetrators of violence?"; "what

are the causes of the different types of violence?"; "how do the different types of violence vary from context to context?" and "how can we use this knowledge to reduce the frequency with which people use violence against one another?". It addresses the underlying societal, community and relationship factors that exert a long-term influence on the likelihood of individuals behaving violently toward other individuals. It also addresses the situational factors that exert a short-term influence on the likelihood of violence taking place (and on the amount of physical and psychosocial harm inflicted), and the post-incident factors that influence the severity and extent of the physical, mental and social harm following violence.

Encyclopaedic reviews of the empirical research on what reduces crime and interpersonal violence have been completed by governments, intergovernmental agencies and university groups in recent years. These include Australia's National Committee on Violence; Canada's Standing Committee on Justice, and Solicitor General; the UK's Audit Commission, Home Office and Treasury, and HM Inspectorate of Constabulary; the United Nations Office on Drugs and Crime; the International Centre for Prevention of Crime; the United States Congress, Surgeon General, and Washington State Public Policy Institute.

The findings of these reviews are highly convergent and agree with the *World report on violence and health* that rates of interpersonal violence can be significantly reduced through well-planned and multi-sectoral strategies that tackle multiple causes, using frameworks such as the public health approach. They are cautious about the extent to which increasing expenditures on policing and corrections will reduce rates of crime and victimization, particularly because of the costs involved to achieve minimal returns (see **Part 3, BOX SIX**). The principal conclusions that these reviews draw are that while policing and corrections are an essential component of prevention, the policing models and types of intervention involved will strongly determine whether or not they are effective (**BOX TWO**).

Target audience

All around the world, the health sector bears the bulk of the interpersonal violence burden because fatal and non-fatal injury and psychological harm are left to health professionals to deal with and treat. In settings where data is available, victims of violence treated in hospital emergency rooms substantially outnumber victims that report to the police, and there is evidence that few victims of violence are seen by both the police and health sector. In addition, the increasing recognition that violence is a public health problem that can be prevented by addressing its underlying causes has expanded the role of the health sector. Interpersonal violence has therefore become a problem to be prevented using the same public health tools of epidemiology, primary prevention and evaluation applied to diseases such as tuberculosis, malaria and HIV/AIDS.

This guide is therefore first and foremost for health-sector policy-makers and programme planners working at national, state or provincial, and municipal levels in technical fields relevant to the prevention of interpersonal violence and the provision of services and support for victims of violence. The relevant technical fields are:

- Health policy and planning
- Epidemiology and health-information systems
- Public health and preventive medicine
- Mental health and substance abuse
- Family and community health
- Emergency medical services
- Medico-legal services.

Although the health sector must take the lead in establishing a preventive response to the problem of interpersonal violence, the involvement of many other sectors (both

BOX TWO

Policing and correctional approaches: expensive solutions to interpersonal violence

Policing will *not* reduce rates of victimization by:

- Increasing budgets, even by large amounts. Instead, this will divert scarce financial resources away from public health and educational programmes that have been shown to significantly reduce crime and victimization;
- Continuing the current policing models based upon patrols, response to calls for service, and investigation – all of which become less and less effective in reducing crime as fewer victims report to the police;
- Using popular programmes such as neighbourhood watch, boot camps and drug resistance education, all of which have been shown to be ineffective in reducing crime and interpersonal violence (**see Part 3, TABLE THREE**).

Policing *will* reduce rates of victimization by:

- Deploying police officers strategically and holding them accountable to target specific problems;
- Adopting models for policing such as the Strategic Approaches to Community Safety, where joint police and university teams analyse the causes of violence, particularly for youth homicides;
- Providing data and collaborating in multi-sectoral partnerships (for example, with schools, welfare and housing) that aim to tackle persistent offending by men who are high-risk because of dropping out of school or having dysfunctional families;
- Targeting repeat victimization – where the same person or address is victimized more than once – through a combination of enforcement, situational crime prevention and social prevention;
- Empowering victims to protect themselves, for instance by creating police stations where female victims of violence know they can talk to female police officers;
- Holding young first offenders accountable through reparation to victims and ensuring they get assistance with life goals through counselling and school participation.

Correctional approaches will contribute to reduced crime and victimization through:

- Investment in programmes that divert offenders from prison to community programmes that are adequately resourced and known to tackle successfully the causes of interpersonal violence and alcohol use;
- Massive increases in the number of persons incarcerated, which can achieve decreases in crime rates for a very high cost – in the USA, increasing the incarceration rate by 250% from 1974 to 2004 is estimated to have decreased the crime rate by 35%, but at costs exceeding US$ 20 billion (enough to provide a job to every unemployed youth or child care for the poor, both of which have been shown to have a much larger impact on crime rates);
- Investment in correctional programme models that have been shown to reduce recidivism. However, these models are few and reduce recidivism by only small proportions.

within government and among nongovernmental and civil society groups) is an essential component in building the type of sustained multi-sectoral response required to prevent interpersonal violence. Within national governments, potential partner sectors include:

- Education
- Employment
- Housing
- Justice
- Safety and Security
- Social Action
- Sports and Recreation
- Welfare.

Private sector collaborative partners include:

- Private suppliers of emergency medical services
- Private health-care groups
- Health and life-insurance industry
- Media outlets including print, television, radio and web-based
- Corporations whose productivity is threatened by interpersonal violence.

From the nongovernmental sector, groups that may benefit from this guide include organizations working directly with communities on the primary prevention of violence

and provision of victim services, and community-based organizations whose work may lead to violence prevention as an important by-product of their efforts, and these include:

- Violence prevention organizations
- Victim associations
- Victim care groups
- Community development organizations.

Research is also fundamental to the development of effective programmes and policies for interpersonal violence prevention. It is therefore crucial that the health sector involve the broader scientific community, including:

- Universities
- Science councils
- Private non-profit research institutes
- Think tanks.

To succeed, a public health approach to the prevention of interpersonal violence must be coordinated and driven by a clearly identified lead agency that can set the prevention agenda while at the same time recognizing and reinforcing the roles played by other essential partners. It is therefore vital that the health sector, led by the Minister of Health, champions the recognition of violence as a public health problem and assertively promotes efforts to implement the recommendations set out in this guide. By following the **Action Steps** for each recommendation ministries of health will become the focal points for spearheading actions by them and the other groups identified as potential partners.

PART 1

Increasing the capacity for collecting data on violence

1.1 Conceptual aspects

The capacity to collect data on interpersonal violence can be defined as the ability to routinely record, analyse and report data covering the consequences and causes of interpersonal violence. The goal of increasing data-collection capacity is to create a system that continually obtains descriptive information on a limited number of key factors that can be accurately and reliably measured for all new cases, or for a clearly identifiable subgroup of all new cases.

Developing the capacity to collect data on the risk factors associated with interpersonal violence and its consequences contributes directly to its prevention at national and local levels by:

- Providing a quantitative definition of the problem that can be shared across different ministries and sectors;
- Providing ongoing and systematic information on the incidence, causes and consequences of violent incidents at local, regional and national levels;
- Enabling the early identification of new trends in violence and emerging problem areas so that appropriate interventions can be established in time;
- Suggesting prevention priorities among those at high risk of experiencing or perpetrating interpersonal violence, and priorities for addressing the associated socioenvironmental risk factors;
- Informing the geographical distribution of emergency medical and other victim-support services;
- Providing information by which to evaluate violence prevention measures that are either direct (for example, enforcement of laws that limit firearm carrying) or indirect (for example, urban renewal);
- Monitoring seasonal and longitudinal trends in the magnitude and characteristics of interpersonal violence and associated risk factors.

The collation of routinely collected, descriptive data – also called a "surveillance system" – must be distinguished from research activities, as described in **Part 2**. The information gathered through surveillance is mostly used at the first step of the public health approach to prevention, that is, for the definition and description of the magnitude, scope and characteristics of the problem. Research, by contrast, is an activity that is usefully employed at each of the four steps. It involves time-limited studies designed to explore specific questions that cannot be answered through the descriptive analysis of routinely collected data. The two types of data collection are thus different but related: information from surveillance can inform research questions and identify areas in which research is necessary. In addition, routinely collected data can be used as outcome and input data for research studies. For example, the relationship between homicide and household income could be investigated by combining routinely collected homicide data with household income information collected during a census.

Sources of data for surveillance

The social and environmental contexts in which interpersonal violence occurs vary between societies and between different groups within societies. One subgroup of the population may, for instance, have easy access to clinics, hospitals and police stations geared to handling cases of violence, while others may live far from such facilities and have a deep-seated mistrust of reporting to authorities of any kind. These contextual differences will shape the help-seeking behaviour of people after violence has occurred and must be taken into consideration when designing a data-collection strategy. Ideally, this can be achieved by conducting a population-based survey in which the incidence of violence and the help-seeking behaviour of victims of violence and their caregivers is

identified. This type of survey could also provide information on community perceptions of particular problems, and on violent events for which people have not sought health-care services. While the results from a population-based survey can invaluably inform the establishment of a violence surveillance system, it is recognized that such an endeavour is resource-intensive and may be beyond the capacity of many programmes as they are getting started.

As noted earlier, health-care providers and victim surveys indicate that many more cases of interpersonal violence occur than are reported to the police, and relatively few cases are brought to the attention of both the police and the health sector. In addition, there are a number of cross-cutting social and economic factors that act at different levels of the ecological model to promote or prevent violence whose characteristics must also be recorded. Systems for collecting data about violence must therefore be broader

BOX THREE

Hospital-based surveillance of violence-related injuries in Jamaica

In almost every setting, at least some of the data sources discussed already exist, but may not have been considered as potential sources of information for the prevention of interpersonal violence. Where this is the case, it is a relatively low-cost exercise to increase the usefulness of such sources by integrating a specially designed violence and injury prevention data-collection form into the documentation process. Examples of settings where this is likely to be feasible include mortuaries and medico-legal clinics where forensic examinations are conducted (for example, on known and suspected non-natural deaths, or on sexual assault victims) and – as illustrated by the following example from Jamaica – hospital emergency rooms that treat victims of violence.

Since the late 1990s, violence has been recognized as a major public health problem in Jamaica, and is a leading cause of injuries and death. In an effort to reduce the impact of violence-related injuries on health-care resources, the Jamaican Ministry of Health (Division of Health Promotion and Protection) in collaboration with the United States Centers for Disease Control and Prevention and the Tropical Metabolic Research Institute, University of the West Indies, Mona, designed and implemented a violence-related injury surveillance system. The system collected demographic, method and circumstance of injury, incident location, victim-perpetrator relationship, and patient discharge status data from individuals presenting at the Kingston Public Hospital Accident and Emergency (A&E) Department to:

1. establish baseline data on the violence-related injuries treated in the hospital
2. describe the risk factors associated with these injuries
3. reduce the impact of violence-related injuries on health-care resources in Jamaica.

From August 1998 to July 1999, a total of 6107 visits involving violence-related injuries were made to the department. Of these, 51.3% occurred among men aged 25–44 years with the highest number of visits occurring in November (13%) and December (12%) of 1998. The most common injuries were caused by stabbing (54%), blunt objects (24%), and gunshots (8%). Of the patients who registered with stabbing and gunshot wounds, 18% and 55% respectively were admitted to hospital. Most of the injuries were sustained during unplanned fights between individuals (70%). In 13% of cases patients were not sure why the violence occurred. In 6% of cases the violence took place during a robbery, and in 2% of cases it was gang-related. Examination of the victim-perpetrator relationship showed that in 49% of cases the perpetrator was an acquaintance; in 10.3% of cases a partner or spouse; in 7.8% of cases a relative, and in 18% of cases a stranger.

Questions on violence were integrated into the existing computerized patient-administration system. Evaluation of the system has shown that data collection was efficient and cost-effective. It added less than two minutes to the registration process, and use of medical records staff to collect the data minimized both personnel costs and any potential increase in workload for doctors and nurses. Initial concerns that patients would not discuss or disclose sensitive information to the medical records staff proved unfounded, although to ensure privacy one of the recording points used a yellow-line system that required patients to wait at a distance until the preceding patient was registered.

Data have been shared with the Jamaican Constabulary Force, the Planning Institute of Jamaica, and other nongovernmental and community-based organizations. The results have also been used to upgrade trauma-care services at Kingston Public Hospital and to justify the appointment of an additional social worker to address patient needs. The mass media has used the findings to heighten public awareness and to plan major violence prevention and control programmes for the inner city of Kingston. The incident location data have been exported into a Geographical Information System to assist in mapping the occurrence of violence in the Kingston metropolitan region. Supplementing the new hospital information with police data and survey data on exposure to violence among inner-city school children has resulted in the identification of "hot spots" for priority intervention activity.

The Jamaican violence-related injury surveillance system demonstrates that even in an environment with limited resources, data on violence-related injuries can be collected and used effectively to plan programmes and guide policy and programme development.

TABLE ONE **Examples of the types of information that may be available from routine data sources**[1]

DATA CATEGORY	POTENTIAL DATA SOURCE	EXAMPLES OF COLLECTED INFORMATION
Mortality	Death certificates, vital statistics registries, reports from mortuaries, medical examiners or coroners	Individual characteristics, cause of death, time, place and location of death
Morbidity and health-related	Hospital, clinic and medical records	Disease, injuries, physical or mental health information, circumstances of injury, injury severity
Self-reported	Surveys, focus groups, media	Attitudes, beliefs and practices, victimization and perpetration, exposure to violence in community and home, risk behaviour
Community-based	Demographic records, local government records	Population counts, income levels, educational levels, unemployment rates
Criminal	Police records, judiciary records, prison records, crime laboratories	Offence type, characteristics of offenders, circumstances of event, characteristics of victims
Economic-social	Institutional or agency records, special studies	Health expenditures, use of services, access to health care, costs of treatments, personal and household income, distribution of income
Policy or legislative	Government and legislative records	Laws, decrees, institutional policies and practices

than crime-information systems and should aim to collate information from the health and policing/criminal justice sectors; from victim surveys; and from other routine data-collection mechanisms such as census counts, demographic and health surveys, and household-income surveys (**BOX THREE** and **TABLE ONE**).

Content of routinely recorded data

Routinely recorded data on interpersonal violence should include information in four key areas:

- **Victim-based information** The occurrence and consequences of interpersonal violence are best measured by bringing together standardized data on individual victims of violence and on the injuries they sustain. For fatalities, the victim's body may be the only evidence that a violent act has occurred. For non-fatal cases presenting at health facilities, medical evidence of wounds and internal injuries can provide objective indicators that violence has occurred. Similarly, when perpetrators do not come forward and when the victims cannot say what happened to cause their injuries (for example, pre-verbal infants, individuals who are unconscious or intoxicated, or the very elderly and infirm) medical evidence may be the only information available.
- **Perpetrator-based information** As with the information derived from victims, perpetrator-based information can be valuable at the aggregate level to show which subgroups of the population are most likely to engage in violent behaviour. In most countries, the police and criminal justice systems will be the main source of such information. For non-fatal violence, however, victims may also be an important

[1] Adapted from Krug EG, et.al. (2002).

source of data about the perpetrator and about the victim-perpetrator relationship. Although the fear of punishment may prevent perpetrators from disclosing acts of violence they have committed, well-designed, non-judgemental survey instruments that are sensitive to the need for confidentiality have been used to establish self-reported perpetration rates in a number of population-based surveys.

- **Risk factors** Routinely available data relating to risk factors include information collected for the purpose of national and municipal census-taking, periodic demographic and health surveys, and household-income surveys. Employment rates and government policy and legislative records may also be useful sources of information, as can the media, which can provide insight into perceptions of and attitudes towards interpersonal violence and its prevention.

- **Risk behaviours** Participating in physical fights, bullying, carrying weapons and alcohol abuse are important risk behaviours for most forms of interpersonal violence. In some settings, information on these behaviours is available from routinely repeated surveys, such as the United States youth risk behaviour surveys, while in other settings it may have been obtained through special studies. Monitoring risk behaviours is essential for evaluating and measuring the impact of interventions that target the behaviours in question (for example, interventions to reduce the proportion of in-school youth that carry weapons).

Setting data-collection priorities

The consequences of violent incidents range in physical severity from those involving the use of weapons (such as firearms and knives) that are more likely to result in death, through incidents that result in victims needing emergency medical treatment and/or hospital admission, to incidents involving psychological and emotional violence that do not produce physical injury. The different sub-types of interpersonal violence are unevenly spread between these physical-severity levels. For instance, youth violence is more likely to result in death than intimate-partner violence, which is more likely to result in injuries of relatively low physical severity but high psychological impact. Furthermore, the availability of and access to health services and police stations will influence the patterns of reporting to these sites, and in situations where such access is limited even homicides and severe physical injuries may not be reported at all. Collecting data on all types of violence will therefore require an approach in which different components of the data-collection system are tailored to obtaining information about violence at different physical-severity levels and in settings with different levels of access to health services and police stations.

In practice, the costs and logistical challenges of implementing ongoing data collection for interpersonal violence at all severity levels mean that such data are usually obtained through intermittent population-based surveys. Countries must therefore make a decision about selecting only certain severity levels for routine data collection, and the following priorities are proposed:

- **Priority 1: data collection for fatal violence** Where data about fatal violence is lacking owing to poorly developed official health and crime information systems, priority must be given to putting in place systems for collecting data on all known and suspected violence and injury-related deaths. It is not always clear whether an injury-related death resulted from intentional or unintentional causes. Collecting data on all suspected violence and injury-related deaths thus avoids the serious underestimates that could otherwise result. Furthermore, the forensic investigation and data-collection systems required for violent and unintentional injury deaths are largely the same.

- **Priority 2: data collection for non-fatal incidents** As second-level priorities, emphasis should also be given to implementing three other mechanisms for the routine collection of data on violence and injury, namely: registries of violence and injury victims admitted to a small sample (2–4) of hospital emergency rooms chosen to reflect the full range of societal conditions; data-collection systems in selected police stations; and population-based data-collection mechanisms such as integrating interpersonal violence questions into routine demographic, health and other surveys.

- **Priority 3: data collection on socioenvironmental risk factors** Routinely collected data about risks in the social and physical environment (for example, on income, education, employment and other important correlates of violence) cut across fatal and non-fatal violence. The responsibility for collecting this type of information will in most settings lie beyond the capacity of a single ministry. The priority for interpersonal violence prevention is therefore to negotiate an agreement on data sharing that allows for the ongoing use of such risk-factor data, for example in the preparation of reports on interpersonal violence.

- **Priority 4: data collection on behavioural risk factors** Both developing and developed countries are increasingly monitoring the behaviours that put people at risk across a broad range of health areas. One of the objectives of behavioural risk-factor surveillance is for data to be collected in a continuous or systematically repeated manner over time so that useful information on trends can be obtained. Although relatively few of these surveys will have been explicitly designed to examine risk behaviours for violence, they will often include relevant variables (such as alcohol and drug use) and can potentially be adapted to include questions specifically relating to interpersonal violence.

1.2 Policy issues

The relationship between policy and the capacity to collect data on interpersonal violence can be considered in the following three areas:

a. Policy support in data collection
b. Data analysis and interpretation to inform policy formulation
c. Data collection for monitoring the impact of policy on interpersonal violence.

a. Policy support in data collection

Policy support for data collection includes laws that mandate for the collection of information on acts of violence and their consequences; laws concerning the promotion and regulation of access to information; and policies that oblige governments to implement such laws. Examples include acts governing inquests and the registration of deaths; legislation on the protection and use of patient information; freedom-of-information acts; and regulations for the standardized reporting of crime.

An essential component in developing the capacity for data collection is therefore to conduct an audit and content analysis of policy and legal supports according to the following sequence:

1. Establish if such policies and laws exist;
2. Make an inventory of those identified;
3. Analyse their content and scope with reference to: population coverage; different levels of physical severity; the information they cover regarding victims, perpetrators, risk factors and risk behaviours; and the extent to which they allow data to be used for public health purposes.

Based upon the results of such an audit, decisions must then be made as to whether there is a need to:

- lobby for the formation and enactment of new policies concerning the collection of data on interpersonal violence;
- amend existing policies and acts where they may be limited by shortcomings;
- increase awareness of sound existing policies and strengthen their implementation.

b. Data analysis and interpretation to inform policy formulation

For a problem to be addressed at a national level its scale and nature must be made visible. This will require both effective analysis and interpretation of data and appropriate presentation of the results to policy-makers. The analysis and interpretation of routinely collected data on the scope, causes and consequences of interpersonal violence therefore have a crucial role to play in putting this issue onto the policy agenda, and in bringing about the enactment and enforcement of policies for its prevention (see **Part 3**). To draw the attention of policy-makers, analyses of data on interpersonal violence must be conducted with the aim of conveying three key messages:

- *Interpersonal violence is a substantial problem* relative to other issues that receive policy attention. The magnitude of the interpersonal violence problem can be demonstrated by comparing it with information on the magnitude of other public health threats; on the size of the problem in other countries; and on the human costs of disasters and collective tragedies featured in the local and international media.

- *Levels of interpersonal violence are sensitive to economic, social and environmental factors* that can potentially be changed to reduce its incidence. Showing that levels of interpersonal violence are sensitive to economic, social and environmental factors that can potentially be changed involves analysing the data according to the geographical place of occurrence and the victims' or perpetrators' place of residence. If such information is used to cluster cases into the same geographical units of analysis used in the national census (or other national and municipal mechanisms for mapping the size, wealth and health of the population) it is possible to examine the correlation between measures of violence and the prevailing contextual factors.

- *Major gains can be achieved* by starting with prevention programmes that address selected high-risk groups, times and situations. **BOX FOUR** illustrates how analyses of homicide data in Colombia by day of week and time of day informed a prevention strategy that was selectively applied to high-risk days and times (Fridays and weekend evenings) and activities (drinking and carrying a firearm) with highly effective results.

When attempting to convey these three important messages it is vital that data on interpersonal violence are presented in reports that deal exclusively with the problem. Reports by statistical offices responsible for crime and health information often include data on violence, but because it is buried among the reporting of many other types of crimes or other health issues it is often difficult to see at a glance how the magnitude of the problem varies over time and between different groups. Extracting the data, analysing it along the lines described above, and presenting it in a focused report using simple language and clear charts and tables is essential in ensuring that this issue is properly brought to the attention of policy-makers and others.

The "visibility" of interpersonal violence as a preventable problem is also strongly enhanced by ensuring that data and the results of data analysis in all these areas are readily available to the media and to civil society organizations. This requires a policy of

BOX FOUR

Analysing fatal injury data to prevent homicide in Cali, Colombia

During 1985–1992 homicide rates in the city of Cali, Colombia increased fivefold to reach levels of 100 per 100 000 people. In response, the city established the Development, Security and Peace Programme (DESEPAZ) in 1992 to implement strategies to prevent violence and improve security among residents. A surveillance system created through partnership and data-sharing between agencies enabled characterization of the patterns and determinants of homicide – information that was key to the formulation of effective policies and a successful programme.

Homicide data were collected daily and reviewed weekly by a committee coordinated by an epidemiologist assigned by the mayor's office. The committee consisted of representatives from the police department, the public health service, the district attorney's office, the ombudsman's office, the National Institute of Legal Medicine and Forensic Sciences, and the Department of Transport. A list of cases was produced from the reports of the different sources represented on the committee, and tabulations and maps of homicides were distributed each week to participating groups and the media.

The information system revealed risk factors at both the individual and community levels. In 1993, a total of 1829 homicides occurred in Cali, representing a crude rate of 104 homicides per 100 000 residents. At the individual level, men aged 25–29 years had the highest rate of homicide (450 per 100 000), and the overall risk of homicide for males was 16 times higher than for females (209 and 13 per 100 000 respectively). 79% of all homicides were committed using firearms. During 1994, blood alcohol concentration (BAC) was determined for 98% of the decedents – in more than one in five cases (23%) it far exceeded the legal driving limit.

At the community level, homicides were clustered in specific areas of the city: 59 neighbourhoods in which 37% of the population resided saw over half of the city's homicides. Homicide rates varied inversely with the socioeconomic status of the neighbourhood of residence of victims, and were highest in the most impoverished areas. In 89% of cases, homicides occurred in the same neighbourhood in which the victim resided, and almost all homicides took place in streets or other public places – only 6% occurred in homes or other residential settings. Homicides were more common (43%) during weekend days (Friday, Saturday and Sunday), especially during weekends coinciding with bi-weekly pay days. The hour of death was known for 2631 of homicides in 1993 and 1994, with 51% occurring between 21:00 and 06:00.

The more comprehensive picture of Cali's homicide problem generated by the surveillance system informed the development of DESEPAZ prevention policies and programmes. Interventions included efforts to enhance public security by enforcing existing state and city regulations and using the mayor's office to issue new decrees and laws. For example, in response to the relation between homicide and alcohol use, the mayor restricted the hours during which alcoholic beverages could be sold. Similarly, the high proportion of homicides committed with guns prompted prohibitions on the carrying of guns in public during high-risk weekends, holidays and election days.

Resource constraints resulted in only intermittent application of the full-range of interventions, which allowed the effectiveness of some interventions to be evaluated. The homicide rates during intervention days were compared with rates during similar days (within the same month, day of week, and time of day) without the intervention. Findings revealed that homicide rates fell 14% when the ban on carrying guns in public was strictly enforced.

At a broader level, continued analysis with the surveillance system showed that the DESEPAZ programme was associated with a significant reduction in homicide, which allowed law-enforcement authorities to devote scarce resources to combating more organized forms of crime. With the programme in operation, the homicide rate in Cali declined 30% from an all-time high of 124 per 100 000 to 86 per 100 000 between 1994 and 1997. In absolute numbers, there were approximately 600 fewer homicides between 1994 and 1997 compared with the previous three-year period. Furthermore, public opinion in Cali shifted strongly from a passive attitude towards dealing with violence to a vociferous demand for more prevention activities.

freely disseminating data so that there are as few barriers as possible to nongovernmental agencies accessing the information. To ensure the anonymity of cases, all shared data must be stripped of the case identification number and any other information that could allow for the identification of individuals.

c. Data collection for monitoring the impact of policy on interpersonal violence

The risk and protective factors that determine the levels of violence among different sectors of the population over different time periods exist at every level of the ecological model. Many are sensitive to social policies in areas such as education and social support and to economic policies that affect income inequality and employment. Policy-driven interventions, such as a social-welfare grant system for families with incomes below the

poverty line, universal access to primary and secondary education, and job-creation programmes, can address the underlying risk factors for interpersonal violence and help to reduce the magnitude of the problem. In addition, judicial policies that affect the availability of firearms and the effectiveness of the police and criminal justice system can also have a major influence on the prevailing levels of violence. Routine collection of data on the scope, causes and consequences of interpersonal violence is an essential part of monitoring the impact of changes in these and other policy areas (see **Part 4**).

1.3 Action Steps to increase data-collection capacity

Developing the capacity to collect data on interpersonal violence involves the following **Action Steps**:

1.1 Identify and review existing sources of information
1.2 Conduct an audit of policy and legal support for data collection
1.3 Develop an initial profile of the problem
1.4 Establish an information working group
1.5 Create a more accurate profile of the problem
1.6 Evaluate data-gathering processes, policies and interventions
1.7 Modify the data-collection system based on evaluation results

A number of technical guidelines and other resources that may be useful in implementing these steps are listed in **RESOURCE BOX ONE**.

RESOURCE BOX ONE

Technical guidelines and other resources for implementing Action Steps for data collection

- WHO Collaborating Centre on Injury Surveillance. *International classification for external causes of injuries*. Amsterdam, Consumer Safety Institute, 2001. http://www.iceci.org
- *International Statistical Classification of Diseases and Related Health Problems*. 1989, Revision, Geneva, World Health Organization, 1992. http://www.who.int.whosis/icd10/
- *Injury Surveillance Guidelines*. Geneva, World Health Organization, 2001. http://www.who.int/violence_injury_prevention/publications
- Sethi D, et. al., eds. *Guidelines for conducting community surveys on injuries and violence*. Geneva, World Health Organization, 2004. http://www.who.int/violence_injury_prevention/publications
- German RR et al. Updated guidelines for evaluating public health surveillance systems. Centers for Disease Control and Prevention, *MMWR*, July 27, 2001/50(RR13):1–35. http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5013al.htm
- Centers for Disease Control and Prevention, *Epi Info 2002*, revision 2 (shareware computer programme for public health surveillance). Atlanta, Centers for Disease Control, 2003. http://www.cdc.gov/epiinfo/

ACTION STEP 1.1

Identify and review existing sources of information

The aim of reviewing existing sources of routinely collected data is to establish "who knows what" about the problem of violence so that questions about the overall profile of the problem and what should be the main priorities in tackling it can be answered. To formulate a complete picture of the problem, several types of data should be compiled from a variety of sources, to the extent possible. Once all the different sources of information have been identified, they can usefully be described using the following four criteria:

- **Type of information** Is the information collected on an ongoing basis as part of a routine information system or is it collected during periodically repeated or one-off surveys? Is the information quantitative or qualitative? Aggregate or disaggregated? These properties will inform whether a trend or only a baseline can be determined, as well as what types of analyses can be performed.
- **Limitations of the data** Potential biases in the data as well as limitations in scope should also be considered. The nature and completeness of data is influenced by many factors, including the circumstances under which the data were originally collected, the purpose for which they were collected, and the primary responsibilities of the collecting agency (for example, industry trend data versus emergency department data). A population-based survey as described above can also help to uncover the limitations of routine data sources. The limitations and potential biases in the data should be recognized in the profile report, as they may affect the generalizability of the findings, and can suggest areas for improved or additional data collection and research.
- **Nature of the information collected** The content of information will vary from agency to agency and may focus upon topics as diverse as the victims of violence; perpetrators of violence; the consequences of violence; the risk factors for violence; or the social and economic costs of violence. Assessing the scope of the data will reveal any gaps there may be in content areas covered by current collection efforts.
- **Confidentiality and information-sharing policy** Depending upon the information source and upon whether the information contains personal identifiers that could compromise the confidentiality of individuals, agencies will be more or less willing to share the information that they collect. Legal restrictions might further impede the linkage of multiple sources of data.

ACTION STEP 1.2

Conduct an audit of policy and legal support for data collection

An audit of policy and legal support should seek to establish what policies and laws exist; to make an inventory of those identified; and to analyse their content and scope with reference to:

- population coverage;
- different levels of physical severity;
- the information they cover regarding victims, perpetrators, risk factors and risk behaviours;
- the extent to which they allow data to be used for public health purposes.

Based upon the results, decisions can then be made on whether there is a need to lobby for the formation and enactment of new policies for data collection on interpersonal violence; to amend existing limited policies and acts; or to increase awareness and strengthen the implementation of sound existing policies.

ACTION STEP 1.3

Develop an initial profile of the problem

An initial – and often incomplete – profile of the interpersonal violence problem can be obtained by bringing together already-collected data from as wide a variety of sources and covering as many relevant topics as possible. The process of identifying sources and gathering data from them requires the establishment of partnerships, a high level of

collaboration, flexibility and open dialogue about the purposes and expected outcomes of collating the data. It can also provide important insights into how different groups or institutions are approaching and dealing with a particular set of problems related to interpersonal violence.

In analysing the data, the limitations of individual data sets and the compatibility and comparability of different data sets will become apparent. While it may hinder the creation of a highly accurate initial report, the challenges to meaningful analysis are useful because they highlight gaps in current data collection and can help guide the programme towards goals and objectives for an improved data-collection system. In addition, initial analysis of even preliminary data can help to flag a major violence "hot spot" – either content-wise or geographical – and assist in setting violence prevention priorities.

Though not ideal as a comprehensive definition of the interpersonal violence problem, an initial profile can be used to attract resources, to enhance interest among potential partners and to establish communication between groups that normally do not engage in any type of collaborative activity – a process that can then be consolidated by the setting up of an *information working group*.

ACTION STEP 1.4

Establish an information working group

Under the leadership of the health sector (as outlined in the **Introduction**), the information working group will oversee the development and maintenance of a violence surveillance system by linking already-established data sets from diverse agencies. The activities of the group will be ongoing throughout the process described in this guide.

An information working group can facilitate the initiation, continuation, and intensification of cross-disciplinary collaboration on the prevention of interpersonal violence. Once existing sources of data have been identified and relationships with the responsible agencies fostered through development and limited dissemination of the initial profile, interested groups can join the multi-sectoral response to the interpersonal violence problem by participating in the information working group.

The first task of the information working group may be to assess the completeness of the initial profile and to identify any gaps; this will assist them with their responsibility to ensure the quality, coverage and sensitivity of existing data sets under their control and any new data-collection mechanisms that they develop. In their analysis of the available data sets, the working group should highlight areas where new measures might need to be created or old ones changed. Furthermore, the group should identify the external strengths and potential obstacles involved in each data source, such as legal barriers to the linking of certain data sets or external obstacles resulting from opposing interests within or from outside the government or community.

The information working group must ensure widespread dissemination of the information gathered and analyses produced from this violence surveillance system. Dissemination can inform the community about the extent of the problem and the factors affecting it; can raise the political profile of the problem within the community; and is essential to ensure that future plans to address it are based on appropriate evidence. Finally, an ongoing responsibility of the working group will be to critically assess the effectiveness of the system that has been created, as well as the quality of the data being produced (see **Action Step 1.6**).

ACTION STEP 1.5

Create a more accurate profile of the problem

A second profile of the problem should be more accurate and more widely disseminated than the first. The collaboration of the information working group can ensure that all potential data sources have been investigated; that limitations of data are more thoroughly recognized and accounted for; and that the data itself is of higher quality. "Data linkage" – the integration of two or more data sets into a single larger and more comprehensive one – should be employed to the extent possible with the available data sets. Data linkage often produces data sets with greater coverage of cases and topic areas that allow for more in-depth descriptions; can potentially identify new priorities or risk factors for use in prevention efforts; and can generate a more accurate picture of the problem. Furthermore, combining the input of all the major participants promotes ownership and acceptance by all as a basis for action and evaluation.

Routinely collected information that claims to represent all cases reporting to (or registered at) a particular service in a municipality is potentially the most readily integrated. For example, all homicides recorded by the police and all known or suspected homicides examined by forensic pathologists within a municipality are two data sets that could be linked. Assuming that each individual case in both data sets has a unique identifier, it is possible to compare the cases included in each of the data sets. Duplicate entries of the same case are excluded and the two sources are combined into a single database of individual-level information.

Integrated information systems can also generate better indicators of the overall problem of violence. These indicators can relate either to violence directly or to risk and other factors important in its prevention. Direct indicators of violence levels include counts of death due to external causes (including homicides, suicides and cases where intent is undetermined); emergency department presentations; and assaults and other violent crimes reported to the police. Risk-factor indicators include information on risk behaviours (for example, firearm ownership and carrying; alcohol and drug use) and non-behavioural risks (for example, percentage of young people in school; social trust; economic inequality). Indicators of other factors in the prevention of violence include information on human, financial and policy resources for prevention (for example, extent of training in violence prevention; percentage of resources spent on primary prevention).

For the creation of a more accurate profile of the interpersonal violence problem, non-linked data sets can also be compared to reveal useful information about the factors influencing interpersonal violence at the community and societal levels. This type of data can be combined with findings from linked data sets to create a more accurate and comprehensive definition and description of the interpersonal violence problem that will be suitable for widespread dissemination to policy-makers, researchers, programme developers and the general public.

ACTION STEP 1.6

Evaluate data-gathering processes, policies and interventions

Evaluation of both the process of creating an information-gathering system as outlined in this section and the resulting policies, programmes and interventions is an important tool for improving the information system, for attracting resources to data-driven violence prevention efforts, and for attracting policy-makers' attention to the issue. A key responsibility of the information working group is therefore to conduct such an objective and thorough evaluation. Information resulting from the evaluation itself should also be disseminated and can frequently enhance the sense of ownership among the different stakeholders.

A process evaluation assesses the successes and challenges of the activities that led to the creation of the information system, including the degree to which the initial objectives have been achieved; the preparation and limited dissemination of the initial profile of the problem; the formation and functioning of the information working group; the process of data linkage and analysis; and the preparation and appropriate dissemination of the second profile of the problem. The criteria presented in **TABLE TWO** are useful for evaluating the information gathering system as a whole. The results of this analysis can be fed back into the process to enhance the functioning of the information working group; to improve the quality of the data, analysis and reports that are produced by the system; and to make the information produced more accessible and useful to programmers and policy-makers.

In addition, an assessment of the policies and programmes that resulted from the information initiative can help policy-makers and programme developers determine whether or not their programmes have yielded benefits to the community. The findings can be used to show the deleterious or beneficial effects of policy changes and to discover the key characteristics of successful programmes, as well as interventions that should not be continued. Thus evaluation is useful for programme improvement and for further programme and policy development.

TABLE TWO Criteria for evaluating an information-gathering system[1]

LEVEL OF USEFULNESS
• Action taken as a result of analysis and interpretation of the data • Entities that have used the data
SYSTEM ATTRIBUTES
• Simplicity (structure and ease of operation) • Flexibility (ability to adapt to changing information needs and operating conditions) • Data quality (completeness and validity of the recorded data) • Acceptability (willingness of persons and organizations to participate) • Sensitivity (proportion of individual cases and interrelated incidents detected) • Predictive value positive (proportion of recorded cases that actually are due to interpersonal violence) • Representativeness (accuracy with which the system describes the actual details of the events under surveillance) • Timeliness (the speed between steps on the surveillance system) • Stability (reliability and availability of the system)

ACTION STEP 1.7

Modify the data-collection system based on evaluation results

Based on the evidence produced during the evaluation process, the information working group should then revisit several of the issues it faced as it was formed and modify these as necessary. In particular, the group should:

- redefine priorities for work;
- articulate a new set of objectives based on what has already been accomplished;
- revise or accept the initial definitions used in the first and second problem profiles;
- implement mechanisms to improve the information-gathering system;
- assess the cost-effectiveness of the participation of multiple stakeholders;
- review compliance with specific stakeholders' needs;

[1] Adapted from German RR, et.al. Updated guidelines for evaluating public health surveillance systems. *MMWR* July 27, 2001; 50(RR13):1–35.

- implement measures to improve the functioning of the working group and its value to participants.

The application of the results of this phase will in turn lead to better sources of information, and thus the cycle of **Action Steps** as summarized in **FIGURE THREE** will return to its initial point of departure.

FIGURE THREE Increasing the capacity for collecting data on interpersonal violence

1.1 Identify and review existing sources of information
- a. Existing data (police, hospitals, mortuaries)
- b. Surveys
- c. Media sources
- d. Local perceptions

↓

1.2 Conduct an audit of policy and legal support for data collection
- a. Establish if such policies and laws exist
- b. Make an inventory of those identified
- c. Analyse their content and scope with reference to: population coverage; different levels of physical severity; the information they cover regarding victims, perpetrators, risk factors and risk behaviours; and the extent to which they allow data to be used for public health purposes

↓

1.3 Develop an initial profile of the problem
- a. Identification of stakeholders and who reports data
  - i. Initial motivation (community concern, political process)
  - ii. Establish individual/collective agreements on data-gathering process
- b. Analysis of information
  - i. Initial assessment of the problem (description of what is known, potential causes of violence, groups at higher risk)
- c. Disseminate currently existing information

↓

1.4 Establish an information working group
- a. Review existing definitions and data-gathering criteria and agree on common definitions of the problem
- b. Agree on shared and individual objectives
- c. Determine strengths and limitations of each source of data
- d. Identify potential barriers to gathering data (quality, opposing interests)
- e. Define collaborators and data-gathering process
- f. Establish dissemination mechanisms and ensure information dissemination

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1.5 Create a more accurate profile of the problem
- a. Develop a more accurate profile of the problem (enhanced description of the problem, more complete and better data)
- b. More accurate definitions of problem, those at high risk, and emerging problems

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1.6 Evaluate data-gathering processes, policies and interventions
- a. Take into account criteria for evaluating data-gathering systems
- b. Evaluate implementation of policies and interventions using data
- c. Disseminate the new information

↓

1.7 Modify the data collection system based on evaluation results
- a. Redefine priorities for work
- b. Articulate a new set of objectives based on what has already been accomplished
- c. Revise or accept the initial definitions used in the first and second problem profiles
- d. Implement mechanisms to improve the information-gathering system
- e. Assess the cost-effectiveness of the participation of multiple stakeholders
- f. Review compliance with specific stakeholders' needs
- g. Implement measures to improve the functioning of the working group and its value to participants

PART 2

Researching violence – its causes, consequences and prevention

2.1 Conceptual aspects

Systematic investigation of interpersonal violence using scientific methods will lead to a better understanding of the problem in different social, economic and cultural contexts, and will greatly enhance the development of appropriate responses. Information obtained through such research can be used to design prevention programmes, assess their effectiveness, and advocate for increased investment in strategies of proven or promising effectiveness. Research is an essential contributor to the achievement of the substantive recommendations addressed in this guide.

The research methods used to investigate interpersonal violence are the same as those used to investigate other public health problems. These include quantitative methods such as longitudinal studies; case-control studies; capture-recapture methodologies; randomized control trials; and cost-effectiveness analysis; as well as qualitative methods such as case studies. Where the skills to perform such research already exist, they can be readily applied to the issue of interpersonal violence without the need for extensive additional training in new research methods.

2.2 Policy issues

Research-based understanding of the social, economic and health-related factors that mediate interpersonal violence is key to the development of policies that are supportive of violence prevention and to the revision of those that may undermine prevention efforts or exacerbate underlying risk factors. Policy development and policy change processes are, however, influenced by political and cultural dimensions, economic and social factors, and scientific and technical evidence. Perceptions of violence are often deeply entrenched in culture-based and gender-based norms, and strongly shaped by a criminal justice perspective. As a result, violence is frequently left out of political discourse on health and social welfare, hindering policy-making efforts in support of violence prevention research or based on its findings.

Institutional resistance to the utilization of public health research findings for policy-making purposes can be countered by building a robust interface between policy-makers and violence prevention researchers. This policy-research interface should be built around two key features:

- a strategic approach to research that focuses attention upon a small set of violence prevention research priorities that have high salience for political leadership and policy-makers in health and other sectors;
- an approach that aims to mainstream violence prevention research questions by integrating them into the national agendas for health and scientific research.

Defining violence prevention research priorities

The priority research areas listed below reflect the research needs for informing action in response to each of the other recommendations outlined in this guide, and can serve as a template for the development of an interpersonal violence prevention research policy agenda. Research priorities in a specific country will be related to the stage of development and maturity of existing violence prevention research activities. The following four stages, each a step of the public health approach outlined in the **Introduction**, can be identified and at each stage specific research topics will need to be addressed if violence prevention efforts at the country level are to progress.

- **Defining the problem** In the early stages, research should focus on defining the problem by addressing questions on the magnitude, types and costs of interpersonal violence. For example, surveillance data could be used to prepare descriptive

epidemiology reports of fatal and non-fatal interpersonal violence; or the economic and social costs of interpersonal violence could be studied.

- **Identifying risk and protective factors** As a firmer base of descriptive research becomes established, greater emphasis can then be placed on identifying risk and protective factors. Some will be modifiable through interventions, and it is on these factors that policy-makers and programme developers should target their efforts. Examples here include case control studies of individuals or families to determine the role of substance abuse in interpersonal violence, or studies of how unemployment rates affect the rates of violence across different communities.
- **Identifying and evaluating potential interventions** Primary prevention and victim care and support services interventions may be developed, implemented and evaluated at local, community, regional or national levels. Programmes at all levels should be tailored to the circumstances and characteristics of the population in which they are to be implemented and should target specifically one or more of the modifiable risk or protective factors identified in the previous stage. Demonstration projects are useful at this point to test the effectiveness of a specific programme model in a particular setting, and evaluation results can inform the implementation of the model on a larger scale at the next stage. At this stage, programme and policy development may benefit particularly from research focused upon adapting evidence-based interventions from one setting to another (such as from high-income to low-income countries); the evaluation of existing primary prevention programmes; the evaluation of victim care and support services; and upon the cost-benefit and cost-effectiveness of promising programmes.
- **Implementing proven and promising programmes** Evidence-based programmes that have been carefully evaluated and that show promising results can be adapted to and adopted in different settings through a widespread implementation effort. Monitoring and evaluation research continues throughout this stage to fine-tune programmes to each individual setting; to monitor overall progress in implementation as well as effects on the targeted risk or protective factors; and finally to assess the impact, cost-benefit and cost-effectiveness of widespread implementation. Here, research could again be usefully employed to examine and assess the degree of success or failure in the scaling-up of a programme and transplantation from one setting to another. Time-series analysis to assess the impact of enacting, changing, or enforcing policies is another example of research that may be useful at this stage.

Mainstreaming violence prevention research

The strategic approach to developing violence prevention research priorities will guide researchers on a path to "mainstreaming" violence prevention, that is, the integration of violence prevention research into national research agendas for health and other science disciplines. At the national level, the dialogue between policy and research is usually conducted through formal mechanisms that establish research and research-funding priorities, and provide communication channels linking policy, action and research. For example, many developing countries have adopted the internationally accepted Essential National Health Research framework (ENHR) for the promotion of health and development to set health research priorities. ENHR's integrated system reflects the input of an inter-disciplinary and cross-sectoral group of stakeholders, combining research evidence and analysis with community participation to share ownership of the agenda among a broad cross-section of the population. Mechanisms such as ENHR identify research priorities that will receive government support – findings from supported studies

are more likely to be influential with health policy-makers (**BOX FIVE**). Integrating research topics from the four stages outlined above into the national health research priority-setting mechanisms can improve the visibility of violence prevention research, increase sustainability of research efforts through increased government funding, and ensure that findings will have a policy impact.

Although health is the core target sector for violence prevention research, the complex and cross-sectoral nature of its causes and consequences may also be meaningfully addressed in other national research forums. Scientific and industrial research councils may have an interest, for example, in developing geographic information systems using descriptive and epidemiological data on violence; in developing new weapons-safety systems which can aid research relating to the prevention of firearm injuries; or in manipulating the built environment to assess its effect on the number and intensity of situational determinants of violence. Some science councils – particularly those that are concerned with the economic, social and human sciences – will often be already investing strongly in strategic research on many of the risk factors and prevention strategies related to interpersonal violence. Finally, private, non-profit research institutes with varying interests and specialized expertise exist in many countries and should also be engaged in the dialogue to mainstream violence prevention research.

BOX FIVE

Violence and injury prevention research in South Africa

In the late 1980s public health oriented research groups started epidemiological investigations into the causes and consequences of violence and injuries as a basis for improved injury prevention and control in South Africa. By highlighting the massive but previously disregarded burden of death and injury due to interpersonal violence, these investigations marked the beginning of a shift away from historical understandings of violence as a largely political or collective phenomenon. The results of these investigations were used to establish pilot violence prevention programmes in some of the low-income formal and informal housing where citizens were identified as being at particularly high-risk for becoming victims and perpetrators of violence, and to argue for the inclusion of violence prevention as a priority health issue.

In the mid-1990s, violence and injury prevention research began to be mainstreamed when the 1996 Essential National Health Research Conference identified violence and injury surveillance for improved violence prevention and control in South Africa as one of the top five national health priorities. In the same year an agreement was concluded for technical cooperation between the United States and South African governments to develop the violence prevention capacity of local agencies. Towards this end the Department of Health hosted a national Consultative Conference on Violence and Heath at which research findings on the magnitude, causes and consequences of interpersonal violence in South Africa were reviewed, and plans for establishing ongoing violence and injury surveillance systems and scaling-up trial prevention programmes were made.

A direct outcome of this conference was the allocation of substantial funding by the National Department of Arts, Culture, Science and Technology for the development of a nationwide violence and injury surveillance system. The system was developed by a consortium consisting of the University of South Africa's Institute for Social and Health Sciences, the Medical Research Council and the Council for Scientific and Industrial Research. As of 2004, the system was focused primarily upon the surveillance of all known and suspected injury deaths (including those due to violence and unintentional causes) and was entering its fourth consecutive year of data collection. The information collected had been used by a wide variety of government and nongovernmental agencies in the design and planning of prevention programmes. In addition, the results have been used to inform a variety of prevention initiatives including the enactment of new legislation governing the ownership and carrying of firearms, assessment of the completeness and sensitivity of national vital statistics and police crime-information systems, and the preparation of national and municipal-level burden of disease estimates to inform health policy and planning.

In 2001, violence and injury prevention research in South Africa was further consolidated by the establishment of a Medical Research Council Crime, Violence and Injury Lead Programme as a joint initiative of the Council and the University of South Africa's Institute for Social and Health Sciences. Establishment of the programme has given violence prevention research the same priority as research into HIV/AIDS, tuberculosis and malaria, and the programme objectives include:

- conducting and disseminating public health oriented research into the extent, causes and consequences of violence and injuries;
- encouraging research to identify, support and develop best-practice examples for primary prevention, and for victim support and care services;
- building capacity among South African researchers to address violence and injuries.

Involving stakeholders

While research itself must be conducted by specialist agencies and institutions with the required technical capacity, mainstreaming violence prevention research can be achieved through a process by which policy-makers and other violence prevention stakeholders at national, regional and local levels (for example, researchers from disciplines other than health; programme developers from service delivery agencies; or representatives from victim associations) contribute to the planning and implementation of a research programme. Breaking barriers between academic research institutions, government and the community leads to shared ownership of the research process, which in turn minimizes resistance to policy and social change and promotes rapid and effective utilization of the research findings. Partners can be engaged at every step of the research process, from the development of research questions, to participant recruitment, through to the dissemination of findings.

Participation by non-academic research consumers in the research process does not compromise scientific objectivity. On the contrary, it will enhance the relevance and utility of research findings for policy-makers, programme designers, and the communities that are the intended beneficiaries of interventions. It will allow for the wider dissemination of results in formats appropriate to a variety of consumers, and a faster and more broadly accepted transition from research to policy and action. For example, involving local businesses, educational authorities, community leaders, religious organizations and the police in designing and implementing a community-based survey of the risks and perceptions of interpersonal violence will increase the level of interest and investment of these groups and thereby increase the likelihood of policy and programme impact.

2.3 Action Steps for researching violence

Acknowledging that all stages of the research process should be informed by (a) an end-user orientation to ensure that results are made accessible to all potential audiences, not just the research community and (b) a need to maximize ownership of both the research agenda and individual research activities, the following **Action Steps** are suggested:

2.1 Highlight the need to study interpersonal violence
2.2 Develop a national research agenda on interpersonal violence
2.3 Identify national research policy frameworks and integrate violence research into them
2.4 Identify and support a national centre for interpersonal violence research
2.5 Establish mechanisms to ensure researcher access to key information sources
2.6 Establish dissemination mechanisms for research findings
2.7 Integrate violence prevention research into undergraduate and postgraduate research training settings.

Technical guidelines and other resources that may be useful in implementing these steps are listed in **RESOURCE BOX TWO**.

RESOURCE BOX TWO

Technical guidelines and other resources for implementing action steps for researching violence

- Council for Health Research and Development (documents and information on country and international partners in Essential National Health Research). http://www.cohred.ch/
- Global Forum for Health Research (aims to focus research efforts on diseases representing the heaviest burden on the world's health and to facilitate collaboration between partners in both the public and private sectors). http://www.globalforumhealth.org/pages/index.asp

ACTION STEP 2.1

Highlight the need to study interpersonal violence

It is important to draw the attention of the research community to the need to study interpersonal violence. The involvement of various stakeholders, the media, policy-makers and the general public can help raise the profile of interpersonal violence prevention research and highlight its importance. In addition, it may be useful for the health ministry to prepare a position paper setting out the arguments for such research and showing how it can contribute to strengthened violence prevention capacity and improved safety.

ACTION STEP 2.2

Develop a national research agenda on interpersonal violence

A national research agenda on interpersonal violence should be developed as a step in creating a national plan of action (see **Part 6**). Establishing such an agenda sets priorities for research in the field and raises the visibility of the subject of interpersonal violence in the research community. Content areas might include the specific research topics suggested above in each of the four stages of conducting violence prevention research, as well as any gaps and issues identified by the information working group (see **Part 1**).

ACTION STEP 2.3

Identify national research policy frameworks and integrate violence research into them

As noted above, dialogue between policy and research at the national level can be conducted through formal mechanisms that establish research and research-funding priorities, and provide communication channels linking policy, action, and research to ensure the prompt and efficient application of research findings. Efforts to mainstream research on interpersonal violence prevention must aim to integrate the topic into these formal mechanisms for transforming research findings into policy and action. Both health research and broader scientific research structures should be targeted.

ACTION STEP 2.4

Identify and support a national centre for interpersonal violence research

A research facility that can become a national centre for interpersonal violence research should be identified and supported in this function. Such a facility may be part of a university or government research council, and may already have a strong track record of conducting violence research or may be new to the field. Either way, it is vital that such a centre be regarded both by government policy-makers and by nongovernmental stakeholders as an impartial source of credible scientific information on interpersonal violence. Supporting such a national research centre will help to foster the production and dissemination of high-quality research and will help to advance the interpersonal violence prevention agenda.

ACTION STEP 2.5

Establish mechanisms to ensure researcher access to key information sources

In order for research to proceed, researchers must have access to key sources of information, in particular the routinely collected data listed in **Part 1**. High-quality data on

interpersonal violence and its underlying risk factors should therefore be readily available to legitimate researchers. The more such data are studied by the research community the greater the understanding of violence and the greater the potential to prevent it. In some countries, high user fees are demanded of researchers wishing to access census and other demographic and health information, and concerns over data ownership and data confidentiality are raised to limit access to cause-of-death data. These barriers can significantly impede the establishment of a new research field, and to promote interpersonal violence research it may therefore be necessary to enter into special agreements with the relevant institutions to waive the fees and ensure appropriate access.

ACTION STEP 2.6

Establish dissemination mechanisms for research findings

Mechanisms must be established to ensure that research findings on interpersonal violence are broadly disseminated beyond the research community to include health practitioners, policy-makers and the public. This is an important step in gaining wider appreciation of the value of such research, and in setting the stage for the application of its findings. Examples of such dissemination mechanisms include exhibitions, websites, newsletters, regular columns in newspapers or other printed media, and news reports and talk shows.

ACTION STEP 2.7

Integrate violence prevention research into undergraduate and postgraduate research training settings

Students in fields such as epidemiology; family and community health; health economics; clinical, counselling, community and social psychology; sociology; social work; nursing science; education; and criminology represent a large pool of potential researchers. At both undergraduate and postgraduate levels, students in these fields are usually obliged to conduct a research project as part of their training. By adding interpersonal violence to the list of possible research topics, national research capacity can be significantly expanded. It may also be useful in this regard to allocate a portion of research funding for bursaries and scholarships that can be offered to attract young scientists into the interpersonal violence prevention field and develop their abilities.

PART 3

Promoting the primary prevention of interpersonal violence

3.1 Conceptual aspects

Although support and care services for victims are important in mitigating the physical and psychological consequences of interpersonal violence and reducing individual vulnerability (see **Part 5**), considerable attention needs to be given to preventing the development and perpetration of violent behaviour in the first place. Promoting the primary prevention of interpersonal violence involves encouraging and supporting the development, implementation and evaluation of programmes explicitly designed to stop its perpetration. Feeding the results of these efforts into the policy process will ensure that lessons learned from experience, and rooted in local realities, will bring maximum benefit. In addition, successful primary prevention programmes will complement efforts to discourage interpersonal violence through the promotion of gender and social equality and equity (see **Part 4**). In terms of the public health approach (see **Introduction**) promoting the prevention of interpersonal violence is both an overall goal and particularly important in relation to step three (development and evaluation of preventive interventions) and step four (implementing effective and promising interventions in a wide range of settings).

Preventing the perpetration of violence

The effectiveness of a particular primary prevention strategy will depend upon a combination of the type of intervention, the timing of its delivery, and the population at risk. Many interventions are developmental-stage specific (for example, infancy, adolescence, adulthood, old age) and the timing of their delivery is crucial. For example, home-visitation and parent-training programmes are effective in preventing child maltreatment and later violence among male adolescents and young adults when delivered during infancy (ages 0–3 years) but are not designed for implementation later in the life-cycle.

As illustrated in **TABLE THREE**, a range of strategies that act at the various stages of development and across the different levels of the ecological model is necessary for the effective primary prevention of violence. Those strategies shown by evidence to have either proven or promising effectiveness must be promoted. Violence prevention resources should not be invested in programmes based upon strategies demonstrated to be ineffective in reducing interpersonal violence and its risk factors – even though they may initially appear to promise rapid prevention effects at relatively low cost or be politically popular. Examples here include providing information on drug abuse to adolescents, training young people in the "safe" use of guns, and peer mediation or peer counselling. The initial promise of such ineffective prevention approaches mean that they are likely to be quite widely implemented, raising concerns over the wastage of scarce prevention resources.

Based upon the scientific literature relating to the epidemiology, aetiology and prevention of violence, several overarching approaches to the primary prevention of violence have been identified, namely:

- **Investing in early interventions** Violence prevention programmes targeted at children or those who influence them during early development show greater promise than those that target adults. Such early interventions have the potential to shape the attitudes, knowledge and behaviour of children while they are more open to positive influences, and to affect their lifelong behaviours. For example, pre-school enrichment and home-visitation programmes, and school-based social-development programmes that teach children social and problem-solving skills have been found to be effective in reducing youth violence and risk factors for youth violence (such as drug abuse) in both the short- and long-term.

TABLE THREE Prevention strategies by developmental stage, ecological context and effectiveness

Strategies in **dark grey box** have been demonstrated to be effective in reducing violence or risk factors for violence.

Strategies in light grey box have shown promise in reducing violence or risk factors for violence.

Strategies in *italics* have been demonstrated to be ineffective in reducing violence or risk factors for violence.

ECOLOGICAL CONTEXT	DEVELOPMENTAL STAGE	
	INFANT AND TODDLER (AGED 0–3)	CHILDHOOD (AGED 3–11)
Individual	• Reduce unintended pregnancies • Increase access to prenatal/postnatal services • Treatment programmes for victims of maltreatment to reduce consequences • Services for children who witness violence	• **Social-development training** • **Pre-school enrichment** • School-based child maltreatment prevention programmes • *Drug-resistance education* • *Gun-safety training*
Relationship (for example, family, peers)	• **Home-visitation services** • **Parenting training** • **Therapeutic foster care**	• Mentoring • Home-school partnership programmes to promote parental involvement
Community	• Lead monitoring and toxin removal • Screening by health-care providers for maltreatment	• Safe havens for children on high-risk routes to and from school • After-school programmes to extend adult supervision • Recreational programmes
	• Community policing • Improving emergency response and trauma care • Training for health-care providers in the detection and reporting of child maltreatment • Promotion of safe storage of firearms and other lethal weapons • Prevention and educational campaigns to increase awareness of child maltreatment • Child-protection service programmes • Services for incarcerated perpetrators • *Gun buy backs*	
Societal		• Reduce media violence • Public information campaigns to promote pro-social norms
	• Strengthen police and judicial systems • De-concentrate poverty • Reduce income inequality	

[1] Adapted from Rosenberg ML et al. *Violence*. Chapter submitted to Jamison DT et al. (Eds) *Disease control priorities in developng countries*, second edition. New York, Oxford University Press.

ECOLOGICAL CONTEXT	DEVELOPMENTAL STAGE	
	ADOLESCENCE (AGED 12–19)	ADULTHOOD (AGED 20 AND OVER)
Individual	**• Social-development training** **• Educational incentives for at-risk, disadvantaged high-school students** **• School-based dating violence prevention programmes** **• Academic enrichment programmes** • *Individual counselling* • *Shock probation or parole* • *Residential programmes in psychiatric or correctional institutions* • *Gun-safety training* • *Boot camps* • *Trying young offenders in adult court* • *Drug-resistance education* • *Programmes modelled on basic military training*	• Incentives for post-secondary education or vocational training • Services for adults abused as children • Treatment for child and intimate partner abuse offenders • Waiting periods for firearm purchases • Owner liability for damage by guns
Relationship (for example, family, peers)	**• Mentoring** **• Family therapy** • Temporary foster-care programmes for serious and chronic delinquents • *Peer mediation, counselling*	
Community	• Recreational programmes • Reduce alcohol availability • Train health-care professionals in identification and referral of high-risk youth and victims of sexual violence • Metal detectors in schools • *Multi-component gang-prevention programmes*	• Reduce alcohol availability • Establish adult recreational programmes • Shelters and crisis centres for battered women and victims of elder abuse • Criminal justice reforms to criminalize child maltreatment, intimate-partner violence, and elder abuse • Mandatory arrest policies for intimate-partner violence • Public shaming of intimate partner violence offenders • Services for identifying and treating elder abuse • Train health-care professionals in identification and referral of battered women, victims of elder abuse, and victims of sexual violence • *Laws permitting gun carrying in public*
	• Community policing • Improve emergency response and trauma care • Disrupt illegal gun markets • Forbid firearm sales to high-risk purchasers • Mandatory sentences for gun use in crimes • Coordinated community interventions for violence prevention • Prevention and educational campaigns to increase awareness of youth violence, intimate-partner violence and elder abuse • *Gun buy backs*	
Societal	• Reduce media violence • Enforce laws prohibiting illegal transfers of guns to youth	• Establish job-creation programmes for the chronically unemployed
	• Strengthen police and judicial systems • Promotion of safe storage of firearms • De-concentrate poverty • Reduce income inequality • Change cultural norms that support violence and abuse of children and adults	

- **Increasing adult involvement** Inadequate monitoring, supervision and parental involvement in the activities of children and adolescents are well-established risk factors for youth violence. Conversely, there is evidence that a warm, supportive relationship with parents or other adults is protective against antisocial behaviour. Given these factors, youth violence would be expected to increase where family structures have disintegrated because of wars, epidemics or rapid social change. Although not widely evaluated, there is some evidence that mentoring programmes that match high-risk children and youth with a positive adult role model can be effective in reducing youth violence. Increasing positive adult involvement in the lives of children and young people appears to be an important element in the primary prevention of violence.

- **Strengthening communities** The community is the environment in which individuals and families interact, and the extent to which it condones or censures violence and its associated risk behaviours (for example, drunkenness) will be an important consideration in prevention efforts. Although far more evaluation research is required at this level, a number of community-based interventions have been identified that show promise in reducing the levels of serious physical and sexual violence and other crimes. These include interventions to reduce the availability of alcohol (for example, through restrictions on marketing approaches aimed at increasing alcohol consumption through price discounting). Furthermore, increasing the availability and quality of childcare facilities may help to promote healthy development and facilitate success in school, while the creation of safe routes for children on their way to and from school and to other activities in the community can prevent victimization.

- **Changing cultural norms** The cultural context plays an important role in violent behaviour. Cultural tradition and social norms are sometimes used to justify practices such as female genital mutilation, abuse of women, the severe physical punishment of children and physical violence as a means of conflict resolution among young males. Cultural norms can also be a source of protection against violence, as in the case of long-held traditions that promote equality for women or respect for the elderly. For the prevention of violence it is particularly important to address norms that associate violent behaviour with masculinity and norms that foster racism, classism, and sexism. Similarly, norms that protect against violence must be promoted.

- **Reducing income inequality** Although poverty itself does not appear to be consistently associated with violence, the juxtaposition of extreme poverty with extreme wealth appears to be universally associated with interpersonal and collective violence. Programmes or policies that reduce or minimize the impact of income inequality may therefore be highly relevant to violence prevention, though the evidence base for such interventions has not yet been established.

- **Improving the criminal justice and social welfare systems** Cross-national studies show that the efficiency and reliability of criminal justice institutions and the existence of programmes that provide economic safety nets are associated with lower rates of homicide. From the perspective of the primary prevention of violence, maintaining a fair and efficient criminal justice system contributes to the general deterrence of violence. Similarly, social welfare institutions that provide basic support for individuals and families in dire economic circumstances may serve to mitigate the effects of income inequality. Improvements and reforms in these systems should be considered as potentially important dimensions of national violence prevention policies and programmes (see also **Part 4**).

Time frame for primary prevention

Interventions targeting different developmental stages and ecological levels will vary in the length of time between implementation and subsequent changes in the rates of violence. Primary prevention programmes must therefore be conceptualized, designed and implemented based on a realistic time frame that takes into account policy, financial, technical and other resources that will need to be sustained for the duration of the programme through to impact. The classification of the effects of primary prevention strategies into rapid, moderate-, and long-delay can be helpful in determining the likely time lag between implementation and impact:

- **Rapid prevention effects** occur either concurrently or within a three-month period following intervention initiation. Rapid effects have been demonstrated for interventions that use closed-circuit television to monitor public spaces for violence; for infrastructure interventions that address factors such as street lighting, visibility and defensible space; and for weapons-oriented interventions (such as reducing weapon-carrying in public). Some primary prevention programmes, such as the DESEPAZ initiative in Colombia (see **Part 1, BOX FOUR**), have simultaneously addressed the combination of firearm-carrying and alcohol sales and consumption to produce rapid and statistically significant homicide-rate reductions. These and other interventions with potentially rapid effects are vital in delivering early prevention successes that can be used to provide political and civil-society stakeholders with proof that violence can be prevented, and to advocate for increased and sustained prevention investments. Drawbacks of most interventions showing rapid effects are that they address only the more visible forms of violence, and that the prevention gains tend to be short-lived and fall off once the intervention is withdrawn.

- **Moderate-delay prevention effects** take effect between 4–36 months following implementation. In contrast to the body of knowledge on interventions associated with rapid and long-delay prevention effects, little is known about interventions that fall into this category. However, the limited available literature and theoretical considerations suggest that moderate-delay prevention effects could be expected to result from youth-oriented interventions that provide mentoring and promote parental involvement; from economic interventions that rapidly reduce economic inequalities, and from interventions that strengthen the efficiency and improve the fairness of the criminal justice system. Early interventions to prevent child abuse and neglect by parents and caregivers have been shown to produce prevention effects as early as 24 months after programme commencement.

- **Long-delay prevention effects** are defined as occurring three or more years post-intervention, although evaluation studies suggest that a time frame of 15–20 years might be more realistic. Early interventions involving home visitation and parent training, social-development training, and pre-school enrichment programmes delivered between 0 and 5 years of age have all been associated with significant reductions in the perpetration of violence among adolescents and young adults 10–15 years after exposure to the interventions. Interventions addressing social norms, economic inequalities, the social environment, and the criminal justice system can also be expected to have long-delay prevention effects. In a political and economic climate that favours "quick fixes", time lags of more than one or two years between implementing interventions and their prevention benefits constitute a serious conceptual barrier to the adoption of such prevention strategies. Politicians and economic planners working with sparse financial resources and a strong pressure to satisfy the electorate are likely to argue that long-delay prevention strategies can only be contemplated at the cost of cutting back on programmes with a promise of rapid prevention effects – an opportunity cost that few would

BOX SIX

Economic value of preventing interpersonal violence

Although few economic evaluations of preventive interventions targeting interpersonal violence have been published (and are mostly from the United States) they all show that such interventions cost far less than the money that they save – in some cases by several orders of magnitude.

The Prenatal/Early Infancy Project (PEIP) – a home-visitation programme for high-risk families in Elmira, New York – was found to have produced overall public-sector savings of US$ 27 854 per child through reduced health and social service use, and savings in the criminal justice and tax systems. A separate evaluation estimated that the PEIP cost the public sector US$ 6550 per participant, while public-sector savings were calculated at US$ 26 200 – a net saving of US$ 19 650 per participant.

A Rand Corporation study compared four types of interventions to reduce youth crime (including violent crime) in the United States: providing high-school students with incentives to graduate; parent training; delinquent supervision programmes; and home visits and day care. All interventions except home visits were found to be more cost-effective than the state of California's "three strikes and you're out" law that incarcerates individuals for 25 years to life if convicted of three serious crimes.

The effects of an in-prison sex-offender treatment programme in Australia were modelled using data from similar programmes active in New Zealand and Australia. The effectiveness of the programme was found to depend on the rate of repeat sex crimes once offenders were released, and estimates ranged from a cost-benefit ratio of 5.0 (with 14% recidivism) to 0.7 (with 25% recidivism). Overall, it was predicted that the programme would be effective, resulting in US$ 26 698 net savings per offender treated. Incarceration and psychological costs that were prevented due to the programme were included in the analysis.

Providing shelters for victims of domestic violence in Arizona was estimated to result in a net social benefit of US$ 3.4 million annually, for a benefit-to-cost ratio between 6.8–18.4. A cost-benefit analysis of the 1994 Violence Against Women Act in the US, which provided for severe criminal penalties against stalkers and perpetrators of intimate-partner violence, found that the law resulted in a net benefit of US$ 16.4 billion, including US$ 14.8 billion in averted victim costs.

accept. It is therefore vital to highlight that while such interventions do indeed have a long delay between delivery and effect, they are also the most effective and cost-effective violence prevention measures identified to date, resulting in savings that exceed their costs by many orders of magnitude (**BOX SIX**).

Scope of primary prevention

Effective and economically meaningful levels of violence prevention can be accomplished through neighbourhood and community-based initiatives, as well as through large-scale programmes that involve whole societies. While some *universal*[1] interventions (mainly involving legal and policy reforms) may be relatively low-cost, many proven and promising universal prevention strategies demand high levels of financial and human resource investments that are recouped only many years later, along with the additional monies that effective prevention saves to society. In resource-poor settings, where it is economically impossible even to contemplate the implementation of universal violence prevention programmes, a better option would be *selective*[2] interventions.

In low-resource settings, selective interventions among the population subgroups and geographically defined communities at the very highest risk of interpersonal violence are strongly encouraged. If properly designed, implemented and evaluated, these selective interventions will be both affordable and capable of producing evidence of impact that can then be used to advocate for the scaling-up of interventions to cover increasingly larger proportions of the population.

Evaluating primary prevention programmes

[1] *Universal* interventions cover entire populations irrespective of differences in risk between subgroups. Examples of universal interventions include laws governing alcohol licensing and sales, and violence prevention components integrated into the curricula of all primary schools.

[2] *Selective* interventions work with population subgroups known to be at elevated risk of perpetrating or being subjected to interpersonal violence. Examples of selective interventions include home visitation to prospective and new parents living in high-crime, low-income communities, or incentives for high-risk youth to complete secondary schooling and pursue higher education.

Programme evaluation is central to step three of the public health approach referred to above (and in **Introduction**) and can be defined as the systematic process of collecting and analysing data using a science-based methodology to determine whether a programme is achieving its stated objectives. Proper evaluation of primary prevention programmes is essential to documenting the occurrence and magnitude of an intervention's impact and its cost-effectiveness – important measures for influencing policy and funding priorities. In addition, evaluation identifies programme strengths and weaknesses for internal improvement, and contributes to the body of knowledge on strategies for interpersonal violence prevention and the replication of effective prevention models.

The importance of evaluation is generally recognized and accepted by prevention experts and policy-makers, and every primary prevention programme should include an evaluation component, no matter how limited. Yet adequate documentation and evaluation of primary prevention programmes is conspicuously lacking from low- and middle-income countries. Challenges to the completion of scientifically rigorous programme evaluation may include:

a) misunderstanding of the purposes, uses and need for programme evaluation, often motivated by the perception by staff that their programme is self-evidently effective and so does not need to be evaluated;
b) resistance to evaluation by programme managers and staff because it is perceived as potentially threatening to their careers;
c) reluctance by government and bi-lateral funding agencies to invest in evaluation because it is regarded as a non-essential "research" activity;
d) lack of technical expertise to conduct an appropriate, meaningful programme evaluation, particularly in local, neighbourhood and community-based initiatives;
e) lack of human resources to complete evaluation activities, as staff are often already overburdened with programme duties and may not have time to complete separate "evaluation" activities.

Although these challenges are common, they can be overcome. The integration of evaluation tools and activities into the programme design and workplan from the onset of programme planning can minimize overburdening of staff and ensure that the appropriate human and financial resources are allocated. Partnerships between research or academic centres and programmes can provide technical assistance and support for proper evaluation design and implementation. Finally, the involvement of programme staff as stakeholders in the planning, division of tasks, and dissemination of results can make evaluation less threatening and can minimize resistance. Sharing relevant evaluation results and positive outcomes that result from the evaluation process (for example, a policy change based on the programme's effectiveness, an increase in funding, or replication of the programme elsewhere) can also demonstrate to employees the importance of evaluation.

Information systems as described in **Part 1** are an essential evaluation tool that can give programme developers, researchers and policy-makers the data they need to feedback into the policy process to ensure sustained resources and to influence policy change. Although the information systems used to monitor deaths, injuries, and other indicators of violence and its risk factors do not in themselves affect the actual rates of violence, they are most useful when established before intervention activities begin. Accessing and analysing data for pre-intervention time periods establishes accurate baseline rates of violence, while continual analysis of regularly collected data throughout the duration of the intervention and afterwards can demonstrate trends and pinpoint the time at which changes in rates of violence-related injury, violent behaviours or risk factors were detected. The ability to determine when change began is crucial to establishing a correlation between an intervention or policy measure and its impact.

3.2 Policy issues

In most countries (with some exceptions), policy and legal instruments explicitly designed to promote programmes for the primary prevention of interpersonal violence will be non-existent. The formulation of such instruments should therefore be viewed as a medium- to long-term goal of advocacy built around the experiences of applied primary prevention programmes, and of the ongoing implementation of a national plan of action for interpersonal violence prevention (see **Part 6**). Because the proven and promising prevention strategies to be promoted will be spread across a range of different sectors, most countries will have numerous policies and laws that indirectly bear upon the primary

BOX SEVEN

Cardiff Violence Prevention Group (CVPG)

From research through local community partnership to legislation and national implementation

During the 1980s and 1990s local and national matching of health and police data in the United Kingdom showed that most violence that resulted in medical treatment was not reported to the police and did not appear in official crime records. According to emergency department (ED) data, there were also marked differences in the recording of age, sex, location and time-specific information by police forces. These findings clearly indicated that the health sector could play a major role in addressing municipal violence, particularly by sharing anonymous violence-related data collected in EDs with police and municipal authorities. Given the low likelihood of such a new policy being universally translated into practice, local implementation was instituted. Municipal officials, senior police officers and health practitioners were brought together to provide a mechanism for local data sharing and integrated joint action. The resulting multi-agency group – the Cardiff Violence Prevention Group (CVPG) – first met in 1996 and prompted further local data matching and verification, and the formation of a local police task force to tackle city centre violence. Subsequently the group attracted major Home Office funding to tackle alcohol-related street crime.

At around the same time, the group came to the attention of the then opposition Labour Party, which was advocating a community-wide multi-agency approach to addressing crime. Following the support of a local member of Parliament, the Labour Party decided that the National Health Service should be a formal partner in this initiative. CVPG acted as a blueprint for municipal-level violence prevention in the official guidance to the 1998 Crime and Disorder Act, the Labour Party's first major piece of crime legislation after coming to power in 1997. The Act put this partnership approach, including health, on a statutory footing and resulted in the formation of 376 similar crime-reduction partnerships throughout England and Wales.

Underpinning the work of these partnerships is the collection of data from multiple sources, and information derived from local EDs is key to directing violence prevention efforts. The core ED data set includes age and sex of the injured, precise assault location, number and sex of assailants, weapon used, and whether or not the assault was reported to the police. ED staff are prompted to initiate police reporting with the permission of the patient or on public-interest grounds if further assault seems likely. Collection of this data has made possible the targeting of violence in particular bars, nightclubs and streets, targeting of assaults with particular weapons such as bar glasses and bottles, and greater cooperation with municipal, transport and leisure industries. The provision of free, private-sector funded telephone lines from ED waiting areas has also increased the reporting of violence to the police and to victim support and women's refuge agencies.

In addition to its core violence prevention role, CVPG also developed an innovative network of services for victims. This network is based in the central Cardiff ED and provides voluntary-sector, traumatic-stress, alcohol-abuse, and maxillofacial services and referral mechanisms based on early identification of mental health and other problems.

Government-funded and other evaluations have found that the CVPG approach has significantly reduced nightclub and bar violence, reduced injuries arising from the use of glass as a weapon (by switching to toughened glass and plastic bottles and preventing people taking glasses and bottles onto the streets), and improved local transport services. In addition, the involvement of ED specialists has greatly enhanced the levels of violence reduction seen with police interventions alone (as a result of data sharing, visits to violence hotspot licensed premises, and published local ED audits of intentional injury).

Important lessons have been learned, including that efforts to tackle violence inside bars can displace the problem onto the street unless police street patrols are also instituted, and that police resources from surrounding suburbs and towns need to follow the migration of young adults from these locations to regional centres on weekend nights. More widely, national audit of all crime-reduction partnerships in England and Wales shows that these local arrangements must have realistic, practical objectives and that all partners need to understand how they can each contribute uniquely.

prevention of violence. Policy and legal instruments from other sectors can be used to lever an initial commitment to (and support for) primary prevention pilot programmes. Examples include:

- Reproductive health-care policies
- Domestic and family violence acts
- Media and broadcasting standards
- Welfare and social support policies
- Alcohol licensing and sales policies and laws
- Educational policies
- Employment policies
- Child care and child protection acts
- Laws regulating firearm ownership and carriage.

When advocating for investment in primary prevention programmes, it is useful to map the links between the proposed programmes and existing policy and legislative instruments. Having this information readily available will considerably strengthen the case for primary prevention, and the exercise will provide a foundation upon which to plan the process of formulating new instruments specific to the primary prevention of violence.

National, provincial and municipal levels

While policy and legal support for primary prevention programmes may often be found and formulated at the national level, the practical work of programme implementation will most frequently be the responsibility of municipalities and provincial authorities (**BOX SEVEN**). The mapping of primary prevention strategies onto national policy and legislative instruments outlined above should therefore be complemented by a similar procedure at provincial and municipal levels.

3.3 Action Steps in promoting primary prevention

The practical dimension of promoting primary prevention focuses on the description, implementation and evaluation of strategically selected prevention programmes. The aim is to provide a local source of evidence and experience for use in advocating for the scaling-up of primary prevention, its integration into routine government work, and the formulation of policies and laws explicitly aimed at primary prevention. As a result, the **Action Steps** in promoting primary prevention are:

3.1 Map existing primary prevention programmes
3.2 Support and evaluate primary prevention demonstration programmes
3.3 Disseminate country-specific prevention experiences
3.4 Advocate for primary prevention
3.5 Integrate primary prevention into routine local and national government work
3.6 Build sustainability mechanisms.

A number of technical guidelines and other resources that may be useful in implementing these steps are listed in **RESOURCE BOX THREE**.

ACTION STEP 3.1

Map existing primary prevention programmes

In every country there are likely to be at least a small number of existing programmes that define themselves as engaged in the primary prevention of violence, and these can provide valuable insight into local violence prevention trends. Such information is crucial

RESOURCE BOX THREE

Technical guidelines and other resources for implementing action steps in promoting primary prevention

- Sethi D, et.al. *Handbook for the documentation of interpersonal violence prevention programmes*. Department of Injuries and Violence Prevention, World Health Organization, Geneva, 2004. http://www.who.int/violence_injury_prevention/publications
- United States Centers for Disease Control Evaluation Working Group (includes step-by-step manuals on how to carry out evaluation, links to other resources, journals and online publications). http://www.cdc.gov/eval/resources.htm
- Injury Prevention Web (includes over 1400 links to violence and injury prevention web sites worldwide). http://www.injuryprevention.org

in ensuring that future prevention efforts learn from past successes and failures, and are focused on delivering proven and promising intervention strategies.

In order to benefit from the experience of existing prevention programmes a systematic approach to programme documentation should be followed, such as that described in the WHO *Handbook for the documentation of interpersonal violence prevention programmes* (see **RESOURCE BOX THREE**) which suggests the following steps:

- Identify all primary prevention programmes in a clearly defined district (for example, within a municipality or a province) – existing mailing lists, prevention networks and directories are all useful sources of information when identifying programmes.
- On the basis of the number and type of programmes identified, decide whether all of them should be investigated or a sample of programmes selected to reflect the full range.
- Contact the programmes to be investigated and negotiate a "programme documentation contract" with the programme managers and programme staff. The contract should allow the sharing of written and verbal information on the programme to enable its systematic documentation and the inclusion of its resulting information in a national programme database.
- Implement a standardized programme documentation instrument that will ensure that comparable information is obtained from different programmes – such an instrument is included in the *Handbook for the documentation of interpersonal violence prevention programmes*.
- Collate and analyse the information from all documented programmes and prepare a report that maps the distribution of documented programmes according to characteristics such as the types of violence they address, the size of the organizations involved, the intervention strategies they deploy, their coverage, and how they attempt to evaluate their impact.
- Establish a database of primary prevention programmes and make it available and accessible to the broader violence prevention community.

ACTION STEP 3.2

Support and evaluate primary prevention demonstration programmes

Demonstration programmes are intended to serve as test-beds for the implementation and evaluation of proven and promising interventions from other settings, and as model programmes to encourage others to adopt and tailor them to their own settings. In

many cases, it is likely that the programmes identified through the mapping exercise above will include one or two that could serve (or with a small amount of additional support could serve) as a primary prevention demonstration programme. These should be formally engaged by the national violence prevention initiative to serve as demonstration projects in exchange for additional financial, technical and political support to enhance their capacity and ensure their viability for at least the next 5–10 years.

Where existing programmes do not have the potential to serve as primary prevention demonstration programmes, then it will be necessary to identify and work with a group of individuals and agencies to initiate a demonstration programme. Experience from countries around the world suggests that this is best achieved through the formation of a primary prevention consortium including members of the community, national and local government, researchers/research councils, the police, health services, and other interested parties.

ACTION STEP 3.3

Disseminate country-specific prevention experiences

Mechanisms for disseminating the experiences and evaluation findings from the mapping exercise and from the demonstration programmes must be established from the outset. Dissemination is essential to:

a) increase awareness that violence prevention is possible;
b) integrate it into the work and policy routines of local and national government;
c) improve primary violence prevention programmes;
d) stimulate violence prevention research;
e) improve collaboration and information sharing within the violence prevention field.

Potential users of information from demonstration programmes include the programmes that were mapped; stakeholders investing in the programmes; advocacy groups; programme developers and researchers in the field; and relevant government groups, including policy-makers.

Representatives from all relevant sectors should be involved from the very beginning of the process and asked to indicate how they would like to receive such information. Using their responses, a selection of different formats for relaying progress and evaluation reports can be designed to meet different needs and preferences. Options for dissemination formats include a project newsletter and/or website; regular reports, meetings, or conference calls; national conferences on the primary prevention of violence; media stories through print, radio or TV; and briefing and position papers.

ACTION STEP 3.4

Advocate for primary prevention

Advocacy is fundamental in promoting the primary prevention of interpersonal violence, and at the very least the following three approaches should be developed.

Advocacy towards government

Advocacy groups outside government have a powerful role to play in promoting primary prevention. Victim associations, for example, may be formed by survivors of violence and relatives of people who have been murdered, raped or subjected to child abuse and neglect. In many countries, such groups regularly participate in initiatives to establish stronger controls over firearms, to prevent child maltreatment, and protect people from sexual violence. Tragic incidents, such as school shootings or the violent death of a high-

profile celebrity, often serve as catalysts for collective concern which, if properly channelled by nongovernmental advocacy groups, can yield rapid and lasting gains in bringing about political will and commitment to primary prevention.

Advocacy by government towards the public

Government-sponsored advocacy campaigns should aim to correct public misconceptions about the causes and preventability of interpersonal violence, and should be coordinated with policy and legislative changes to heighten public awareness of new laws and policies. Such campaigns can promote and popularise the idea of preventing violence, and draw everyone into efforts to achieve this.

Advocacy within the health department and towards other government departments

Applying primary prevention principles to the problem of interpersonal violence is likely to be a new idea to many government ministries and technical departments that are required to collaborate in policy change and programme implementation. Advocacy within government should aim at explaining the public health approach to interpersonal violence prevention through seminars, workshops and newsletters informing relevant individuals about the prevention of violence, and inviting them to discuss their potential roles and responsibilities.

ACTION STEP 3.5

Integrate primary prevention into routine local and national government work

Integrating the primary prevention of violence into planned social development, educational and urban renewal projects can be achieved by requiring that such plans include the prevention of violence as an explicit goal, and that appropriate indicators are included to measure levels of interpersonal violence before and after project implementation.

Reducing the risk factors for interpersonal violence should also be taken into account in the planning of all new major social development projects. The potential effects of such projects on interpersonal violence and its risk factors must be identified through social-impact analyses -- project approval should be given only to projects that demonstrate a high likelihood of reducing interpersonal violence.

ACTION STEP 3.6

Build sustainability mechanisms

The primary prevention of interpersonal violence should be established as a standing line item in the budgets of the health, justice, education, welfare and security ministries, and a portion of the national research and development budget should be allocated to scientific research into primary prevention. The setting up of a national centre for the prevention of interpersonal violence should also be supported, either as an independent entity or as a unit located in a pre-existing institution or programme with the necessary infrastructure and reputation as a centre of public health excellence.

PART 4

Promoting social and gender equality and equity to prevent violence

4.1 Conceptual aspects

Although their effects on interpersonal violence are not the sole or main reason for their importance, an essential component of violence prevention is to promote both social and gender equality and equity. Gender and social inequalities and inequities, as indicated in **FIGURE TWO** in the **Introduction** to this guide, are related to many of the major risk factors common to multiple types of interpersonal violence and act as risk factors themselves, particularly at the societal level of the ecological model. They can exacerbate other risk factors across the ecological levels to facilitate conditions in which violence can thrive. Conversely, increased equality and equity can multiply the effects of protective factors to reduce levels of violence.

Promoting social and gender *equality*[1] alone is not enough to influence the underlying conditions that foster interpersonal violence. Two groups within society could achieve, for example, equal status before the law and legal protection against discrimination, yet inequity might remain because of the differences in the way the groups are positioned to take advantage of opportunities. Consider the hypothetical example of a foundation that wishes to award grants for 10 violence prevention projects in a specific region. The call for proposals goes out to every country in that region welcoming submissions – there is equality of opportunity. However, countries that have developed capacity in violence prevention and have experience with grant-writing will prepare sound proposals and are thus more likely to be awarded grants than countries preparing proposals in this field for the first time. Such a process will probably result in an inequitable distribution of grants, biased toward countries with greater existing capacity. To avoid this outcome – to promote equity – the foundation would need to offer assistance with proposal preparation to those countries with little experience. The example illustrates that equality is not always enough to ensure equitable outcomes and that achieving equity often requires differential treatment in favour of historically disadvantaged groups.

Though not the only means, policy development and implementation can make important contributions to achieving social and gender equality and equity. Policy can both provide legal protection from discrimination (to promote equality) and improve the access of groups to opportunities and resources (to improve equity). Though positive policy measures are one key step towards equitable social conditions, it is important to remember that inequities are not the result of poor policies alone, but also of discriminatory attitudes and social norms. Changing policy will have some impact on social norms, but the involvement and commitment of leaders and policy-makers, along with public awareness campaigns, social marketing and other communications strategies, are often required to bring about sustained efforts for social change.

4.2 Policy issues

Social policy

Social policy can be used to improve social equality and equity by improving access to (and fair distribution of) essential resources such as health, education, quality housing and social services. In addition to fulfilling basic human rights (**BOX EIGHT**), such improvements address some of the major cross-cutting risk factors for interpersonal violence and should result in reduced levels of violence.

"Social policy" does not have a standard definition and policy-makers and academics tend to use it to mean different things. The term is applied here to refer to policies that

[1] *Equality* refers to fair access to opportunities and resources and occurs in the absence of discrimination based on personal characteristics such as race, sex or class. *Equity* comprises fairness in the distribution of benefits, responsibilities and resources across social structures and institutions. Disparities that are unfair, unnecessary and avoidable, especially when they systematically burden vulnerable groups, constitute inequities, for example the exclusion of girls from primary schooling; or the use of ethnicity, income or education as a criteria for eligibility for social services.

BOX EIGHT

Human rights and the prevention of interpersonal violence

Although various forms of interpersonal violence – including violence against women, child abuse, and elder abuse – have been recognized as human rights violations, it is less well understood that the degree to which human rights are protected and fulfilled directly influences the conditions that give rise to such violence.

States that have ratified the international instruments enshrining these rights are obligated to *respect* them (meaning that governments should refrain from their direct violation); to *protect* them (meaning that governments are expected to implement reasonable measures to prevent rights violations and to allow for redress if this occurs); and to *fulfil* them (by taking steps to ensure that they are realized, not merely protected). Specifically for violence, States must ensure that they are not committing acts of violence against individuals; that victims of violence have access to services and redress for violations that do occur (whether by public-sector or private actors); and that individuals, communities and society enjoy peace and safety.

Social and gender policy can be mechanisms for meeting human-rights obligations, and conversely, human-rights obligations in accordance with international law provide a rationale for improvements in these policy areas. Basic human rights include the right to an adequate standard of living, the right to the highest attainable standard of health, the right to social security, the right to education, and the right to equality and non-discrimination. These economic, social and cultural rights have a direct bearing on poverty, economic and gender equality, unemployment, substance abuse, and weak social safety nets – the same underlying and cross-cutting risk factors for interpersonal violence as depicted in **FIGURE TWO** (in the **Introduction**). Where human rights are respected, protected and fulfilled, levels of interpersonal violence are likely to decrease.

establish welfare and social protection programmes to safeguard the well-being of citizens, and may be directed either at the general public or at certain groups (such as the young or the elderly). Good social policy can help to mitigate the effects of inequities arising from poverty, unemployment, social isolation, and rapid social change. Social policy can be a strategic tool for shaping the underlying societal conditions that determine well-being and can, in that role, encompass education; employment; social protection (for example through income assistance or unemployment benefits); housing; and health.

Economic and fiscal policies are generally considered to be distinct from social policy, even though their outcomes (such as income distribution, wages and employment levels) have important social consequences. Adjustments of economic and fiscal policy designed to strengthen the economy do not necessarily lead to increased social equity and may even worsen the situation of a country's poorest citizens. Where economic and fiscal policy has failed to guarantee citizens their basic social needs, social policy can partially address the gap.

Desirable outcomes of social policy that are particularly relevant to violence prevention due to their bearing on cross-cutting risk factors include:

- Increased access to, and quality of, early childhood education and care
- Improved (and equal) access to primary and secondary education, including adequate resource allocation for education
- Reduced unemployment rates
- Stronger social-protection systems (for example, social security for the elderly and disabled; health insurance; child care; income and/or food supplementation; and unemployment benefits).

The ability to achieve these outcomes in countries will be influenced by factors such as the national economy, available resources, and policy environment and priorities. It is not possible in this guide to recommend specific social policies that will be relevant and effective in all contexts. Instead, a number of preliminary **Action Steps** in addressing interpersonal violence through social policy are outlined below.

Because social policy encompasses so many areas, it is important to choose strategically which areas to address initially. Ideally, this decision should be based on national data indicating which societal factors are most strongly related to interpersonal violence. In most situations, however, such data will be lacking. Where there is no strong data to

guide priorities, this guide recommends beginning with education, social protection and employment policy (**BOX NINE**).

For social and economic policy to offer maximum benefit to human development, they must be mutually supporting and therefore closely coordinated. As expressed in various policies and strategies of several regional bodies, including the Organization of American States, the European Union and the Council of Europe, good social policy is not only good for social equity but also contributes to economic growth and strength. Conversely, economic growth is a means of securing human development through fulfilment of basic social rights such as the right to an adequate standard of living and the right to education. Securing basic economic and social rights through coordinated economic and social policy will reduce poverty levels and societal inequities. Effective policies will also result in decreased levels of interpersonal violence by mediating key cross-cutting risk factors, even if they do not incorporate explicit violence prevention objectives.

BOX NINE

Addressing poverty and inequality to prevent interpersonal violence

Both poverty and economic inequality are important community- and societal-level risk factors for interpersonal violence. Many studies have confirmed that high levels of poverty and inequality can create conditions that allow violence to flourish. Most studies that have explored the effects of these risk factors on interpersonal violence have focused on homicide. In terms of absolute poverty, higher levels of poverty and lower levels of economic development have been shown to be associated with higher homicide rates, and studies of relative poverty have found economic inequality to be an even stronger predictor of interpersonal violence rates. The latter effect likely results from the association of economic inequality with other risk factors such as unemployment, weak economic and social safety nets, economic deprivation and social disintegration. Since these factors in turn mediate the situation of households and individuals, it is no surprise that low household socioeconomic status has been established as a relationship-level risk factor for violence. In light of these associations, measures to alleviate poverty and reduce economic inequality are clearly instrumental to the wide-scale prevention of interpersonal violence.

Major players in international health and development have already recognized the importance of poverty reduction (for example, the World Bank's Poverty Reduction Strategy Papers, WHO's work on the macroeconomic determinants of health, and the Millennium Development Goals) and much work in this area is already underway. Correlational studies suggest that the overall rate of economic growth or decline in a country predicts changes in homicide rates. The rapid changes occurring in societies and economies around the world in the course of globalization can exacerbate inequality, which can lead to increased levels of violence even in the context of reduced levels of poverty. The greatest gains in violence prevention will be made when poverty reduction and economic development are accompanied by policies that promote an equitable distribution of the benefits of economic growth and minimize the negative effects of rapid social and economic change.

Gender policy

In addition to being essential for fulfilling human rights, especially women's human rights, promoting gender equality and equity is a critical component of violence prevention. Discrimination based on gender and unfair distribution of opportunities, power and resources between and among men and women are underlying causes of interpersonal violence. Gender policy can help address the inequities that result from gender-based discrimination by securing equal treatment in the law, equal rights, and equal access to opportunities for men and women, as well as improving fairness in the distribution of benefits (for example, access to credit) and responsibilities (for example, household work) among men and women. Policy measures to promote equity should focus on disparities between and among women and men that are unfair, unnecessary and avoidable.

The strategy of incorporating gender concerns into all policy is referred to as "gender mainstreaming". The United Nations Economic and Social Council defines gender mainstreaming as follows:

> *...the process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in any area and at all levels. It is a strategy for making women's as well as men's concerns and experiences an integral dimension in the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres so that women and men benefit equally and inequality is not perpetuated. The ultimate goal is to achieve gender equality.*
>
> E/1997/L.30 Para Adopted by ECOSOC 14.7.97

Gender analysis of policies and policy outcomes is part of the gender mainstreaming process. In the pursuit of gender equality and equity, a two-pronged approach of both adopting dedicated gender policies and giving attention to gender equality and equity in policies usually considered to be gender-neutral will be most effective.

Gender inequality and inequity in society generally work to the advantage of men – safeguarding women's human rights and equal status is therefore paramount and may require differential treatment in favour of women to correct inequities and inequalities arising from the historically unequal power relations between men and women. The Beijing Declaration and Platform for Action, adopted by governments at the Fourth World Conference on Women in 1995, indicates several desirable policy goals and outcomes for improving the status of women, including provision of access to credit mechanisms and institutions to women; elimination of female illiteracy; increased access to health care for women; ensuring women's access to power structures and decision-making; and prevention and elimination of violence against women. The standards set forth in the outcome documents of the Beijing conference and its follow-up meetings should be used as a guide when formulating and evaluating gender policies and gender mainstreaming.

Violence against women (VAW) cuts across all types of interpersonal violence, and must be addressed as a component of gender inequality and inequity. VAW is not only a manifestation of unequal power relations between men and women, it is a mechanism for perpetuating inequality. The violence directed at women and girls, often because they are female, can prevent them from obtaining equal status and full enjoyment of their human rights. As stated in the Beijing Platform for Action, fear of this violence can function as a barrier that limits women's access to opportunities and resources. Specific measures to address and eliminate VAW should be incorporated into any strategy for the promotion of gender equality and equity.

Strategies for preventing interpersonal violence should give special attention to violence against women, but the impact of the uneven distribution of risk factors and consequences on men should not be overlooked. Interpersonal violence is a leading cause of death for men in every world region. Men are most at risk of fatal violence or severe injury inflicted by strangers or acquaintances, while women are most likely to experience non-fatal violence by relatives, friends and intimate partners. The cause of these differences should be investigated, and attention must be given both to the prevention of VAW and the reduction of male homicide and severe intentional injury rates.

4.3 Action Steps in promoting social and gender equality and equity

Successful methods for promoting social and gender equality and equity are not necessarily easy to identify or implement, but both social policy and gender policy are tools with which equality and equity can be improved and violence prevented. Taking stock of existing policies and evaluating the social and gender impact of proposed policies is one way to begin work in this area, and the relevant **Action Steps** include:

4.1 Advocate for effective social and gender policies
4.2 Conduct a review of existing social policy
4.3 Conduct a review of existing gender policy
4.4 Promote gender mainstreaming in the programmes and policies of ministries
4.5 Subject proposed social and gender policies to social impact assessment.

A number of technical guidelines and other resources that may assist in the promotion of gender and social equality and equity, and in the integration of violence prevention into gender and social policies are listed in **RESOURCE BOX FOUR**.

RESOURCE BOX FOUR

Technical guidelines and other resources for implementing action steps for promoting social and gender equality and equity

- United Nations Department of Economic and Social Affairs, Division for Social Policy. http://www.un.org/esa/socdev/
- International Covenant on Economic, Social and Cultural Rights (1966). http://www.unhchr.ch/html/menu3/b/a_cescr.htm
- International Covenant on Civil and Political Rights (1966). http://www.unhchr.ch/html/menu3/b/a_ccpr.htm
- International Convention on the Elimination of All Forms of Racial Discrimination (1965). http://www.unhchr.ch/html/menu3/b/d_icerd.htm
- Convention on the Elimination of All Forms of Discrimination Against Women (1979). http://www.unhchr.ch/html/menu3/b/e1cedaw.htm
- Beijing Declaration and Platform for Action. United Nations (1995) Platform for Action in *Report of the Fourth World Conference on Women*, Beijing, 4–15 September 1995 (United Nations publication, Sales No. E.96.IV.13), chap. I, resolution 1, annex II. http://www.un.org/womenwatch/daw/followup/beijing%2B5.htm
- Landsberg-Lewis I, ed. (1998). *Bringing equality home: the convention on the elimination of all forms of discrimination against women*. New York, NY. UNIFEM. www.unifem.org
- Office of the Special Adviser on Gender Issues and Advancement of Women (2002) *Gender mainstreaming: an overview*. New York, NY. United Nations Department of Economic and Social Affairs. http://www.un.org/womenwatch/osagi/statementsandpapers.htm
- Spindel C, Levy E, Connor M (2000). *With an end in sight: strategies from the UNIFEM trust fund to eliminate violence against women*. New York, NY. UNIFEM. www.unifem.org

ACTION STEP 4.1

Advocate for effective social and gender policies

Promoting social and gender equality and equity through social and gender policy requires convincing decision-makers to implement policies that may take years to bring about the desired results. Advocates need to understand what type of arguments and rationales motivate the decision-makers responsible for these policy areas and to tailor their strategy accordingly with a mixture of human rights, health, and cost/benefits arguments. To accomplish this, it is important to understand the local context within which policy is created, adopted and implemented by the government as well as the social and political environment. In addition, advocates must continue their work even after a policy is developed and adopted to help establish policy implementation frameworks and monitoring mechanisms. Monitoring the implementation of a policy and its effects are of utmost importance to ensuring the desired outcomes. One feature of polices that aim to reduce social and gender inequalities over long time frames (for example over 10–20 years) is that they can provide an excellent supportive structure for the primary prevention programmes discussed in **Part 3**.

ACTION STEP 4.2

Conduct a review of existing social policy

Whether explicitly labelled or not, every country has policies that shape societal conditions and therefore employs social policy of some kind. The first step in reviewing social policy is to discover what policies actually exist and how they are being implemented. The following questions should be investigated:

- Is there a national education policy?
- What policies do the Ministry of Education employ?
- Is there a national policy governing social protection? Multiple policies?
- What policies are employed by the Ministry of Social Welfare (or equivalent)?
- Is there a national employment policy?
- What are the Ministry of Labour's policies related to employment?

After discovering which policies have actually been adopted, it is important to conduct a content review that answers the following questions:

- What issues do existing social policies address, and how?
- Is the reduction of social inequalities and inequities a stated policy goal, and is it accompanied by specific objectives?
- Do the policies explicitly address discrimination and contain measures to eliminate it (i.e. promote equal access to education for boys and girls, and for rural and urban populations)?
- Are the policy goals time-limited and, if so, what are the limits?
- What are the major policy gaps?

Finally, policies are ineffective unless they are implemented. The wording of a policy may reflect some amount of commitment to an issue, but the real degree of commitment will only become apparent following an evaluation of how the policy is reflected in budgets and actual appropriations, and how fully it is implemented. In the case of laws, it is also important to evaluate whether or not they are enforced. Even if something is made a criminal offence by law, this will be of little use if in practice there are few arrests and even fewer convictions.

As social policy is only an indirect prevention measure, a means of linking it to violence prevention is necessary, and can be facilitated through systematic mechanisms for analysing existing and new policies for their effects on interpersonal violence. This can be done either through correlation (where statistics are available – see section **1.2**) or by content and impact analysis with reference to theoretical models for violence prevention.

All the above steps should lead to an accurate assessment of what the current policy context is and of what the gaps are. A report should be produced detailing the results of the process of policy review, and should include recommendations for specific **Action Steps** to improve social equality and equity. Based on the results of the content analysis, four types of actions should be considered:

- to advocate for new policies to fill in identified policy gaps;
- to change existing policies that are detrimental to equality and violence prevention objectives;
- to build violence prevention objectives into already-existing social policies;
- to stay aware of policy trends and support the implementation, enforcement and protection of policies that favour violence prevention goals.

When formulating recommendations, it should be noted that enacting new policies and changing existing ones is a time-consuming and difficult process. Benefits and resource expenditures should be weighed up, but the latter two options for action may prove to be the most promising and productive.

ACTION STEP 4.3

Conduct a review of existing gender policy

As stated previously, achieving gender equality and equity are worthy goals in their own right and a means of reducing violence. Additionally, improving equality and equity between the sexes can contribute to the prevention of interpersonal violence, particularly violence against women. The desirable outcomes of policies in this area therefore encompass both general improvements in relations between the sexes and specific reductions in gender-based violence. The policy means of achieving these outcomes have been well discussed in the context of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Beijing Declaration and Platform for Action (see **RESOURCE BOX FOUR**) though prescriptions will vary according to the local context.

As in the case of social policy, a gender policy review is a good first step in efforts to improve gender equality and equity, and should begin with the following inquiries:

- Is there one ministry that has responsibility for policy related to women?
- Is there a national gender policy? Does it address both women's and men's needs?
- How are gender issues mainstreamed in other ministries?
- What ministries have adopted gender policies to guide their institutional functioning?
- Has the country ratified CEDAW?
- If so, is there a plan for implementation?
- Did the country sign the Beijing Declaration and Platform for Action of the Fourth World Conference on Women?
- Has it submitted a national action plan, as required by the Platform for Action, to the United Nations Division for the Advancement of Women?[1]
- What are the laws and policies related to violence against women?

Again, after determining what policies exist, a review of their content and an impact analysis with respect to violence prevention should be carried out.

As with social equality and equity, the existence of a gender policy may indicate some amount of commitment, but the degree will only become apparent following an evaluation of how the policy is reflected in budgets and actual appropriations, and how fully it is implemented. For example, both the Beijing Declaration and Platform for Action and CEDAW offer specific recommendations for improving the status of women and for eliminating violence against them, and an assessment should be made of how much these have been integrated into national policy and how well they are being implemented and enforced. This information may already be available as those States which are party to CEDAW are bound to report at least every four years on the measures they have taken to implement the convention.[2] In addition, nongovernmental organizations often submit "shadow" reports to supplement country information. Further indicators of implementation may also be found in reports by institutions such as Human Rights Watch or the Inter-American Commission on Human Rights, which describe the state of human rights and women's rights in various countries.

As with the social policy review process, a report detailing the results of the gender policy review should be prepared, and should include recommendations for action steps to improve gender equality and equity. The report should also include a gender analysis of violence in the country, discuss aspects of gender policies specifically targeting violence, and show how these affect both males and females and how they can be applied or adapted to mitigate the impact of violence on both.

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[1] http://www.un.org/womenwatch/confer/beijing/national/natplans.htm

[2] Some of these reports are available online at http://www.un.org/womenwatch/daw/cedaw/reports.htm

The same four potential actions apply to gender policy as for social policy (see **Action Step 4.2**), but because gender policy is a newer field, the emphasis may be on advocacy for new policy, rather than on the other steps. In particular, States that do not have a national policy on violence against women should develop such a policy as the first step. States must make it clear that violence against women will not be tolerated, no matter where it occurs or by whom. All forms of violence against women should be criminalized and adequate funds appropriated for prevention efforts and health, social and legal services for victims.

ACTION STEP 4.4

Promote gender mainstreaming in the programmes and policies of ministries

It is difficult to offer a blueprint for gender mainstreaming, as the implementation process differs according to the target activities (for example, policy development, policy analysis, research, programme design). The key objective for any area of work is to bring gender equality/equity concerns into the mainstream planning and analytical process instead of dealing with them as an addendum. As the scope of this guide does not permit an in-depth explanation of gender mainstreaming strategies, readers are encouraged to utilize resources such as the gender mainstreaming tools available from the United Nations Office of the Special Adviser on Gender Issues and Advancement of Women (see **RESOURCE BOX FOUR**) and the recommendations developed by the Inter-American Commission of Women (CIM).[1]

As part of the Organization of American States (OAS), CIM has been working with OAS member states on mainstreaming gender in the programmes and policies of labour, justice and education ministries, highlighting the opportunity these sectors have to improve gender equality. CIM's work on gender and education provides an example of the kind of work that can be done as advocacy and for implementation of gender mainstreaming. The Third Meeting of Ministers of Education (OAS member states) in 2003 committed to promoting equity, quality, relevance and efficiency in education, including elimination of gender disparities in primary and secondary education. CIM developed a set of recommendations for incorporating a gender perspective in education:

1. Ensuring equal opportunity for men and women in access to all levels of the education system;
2. Promoting non-sexist education;
3. Use of the education system to encourage greater participation of women in the labour force;
4. Contribute to the strengthening of education ministries from a gender perspective;
5. Eliminate sexist messages and materials in the media and encourage the media to educate society on gender equality.

Each recommendation consists of specific objectives and actions for practical application, including gender analysis of reasons for dropping out of school, eliminating gender discrimination in curricula, and increasing educational levels of women – including adult literacy. It is through consensus recommendations such as this that CIM is assisting OAS member states to identify how they can improve gender equality and equity by including gender concerns in all major policy areas, rather than relying upon a dedicated gender policy.

[1] Available at http://www.oas.org/cim/ - under Ongoing Projects: Incorporation of a Gender Perspective in Ministerial Level Meetings.

ACTION STEP 4.5

Subject proposed social and gender policies to social impact assessment

In addition to reviewing existing policies, any proposed policy must be evaluated for its potential impact on social and gender equality and equity, and on the levels of interpersonal violence. Social impact assessment is a technique for predicting the potential social consequences likely to result from implementing a proposed policy. Social impacts are defined as:

> *...the consequences to human populations of any public or private actions that alter the ways in which people live, work, play, relate to one another, organize to meet their needs and generally cope as members of society. The term also includes cultural impacts involving changes to the norms, values and beliefs that guide and rationalize their cognition of themselves and their society.*
>
> United States Department of Commerce, 1995

Consideration must be given not only to the social impacts themselves, but to their distribution between the sexes and across different population groups (for example if rural populations are more likely to be negatively affected than urban populations). Social impact assessment must include gender analysis. If conducted properly, social impact assessments can provide information on the likely effects of a policy on various determinants of interpersonal violence, or may include violence as one of the outcomes to be used in the assessment model.

PART 5

Strengthening support and care services for victims

5.1 Conceptual aspects

In addition to promoting the primary prevention approaches described in **Part 3**, providing quality support and care services to victims is an essential component of any response to interpersonal violence. Appropriate services for victims of non-fatal violence can prevent future fatalities, reduce the amount of short-term and long-term disability, and help those affected to cope with the impact of violence on their lives. The specific aims of strengthening such services are to:

- treat injuries and minimize harm and suffering in both the short and long term;
- reduce the likelihood of secondary victimization – both intentional and unintentional – by service providers;
- facilitate redress through the criminal justice system where possible;
- reduce the likelihood that individuals will suffer repeat victimization in the future and the likelihood that victims themselves will become perpetrators.

Minimizing harm

When an act of violence cannot be prevented, high-quality services can minimize all forms of harm caused to the victim. In many ways, the consequences of interpersonal violence are most likely to affect a victim in the long term, potentially leading to depression, suicidal behaviour, substance abuse, or violent acts toward others. Harm will be minimized when the individual's medical, psychological, social and legal needs are all met. Although the health sector alone cannot offer services to meet all these needs, an initial interaction with health services offers an opportunity for referral to other services. Those planning health services for the victims of interpersonal violence must, then, also take into consideration the non-medical needs of the injured and connect with the sectors responsible for meeting those needs.

Though physical and social rehabilitation and long-term care are important aspects of responding to violence, the recommendations in this guide focus on services rendered in the acute phase after the violent act occurs or is disclosed. Access to quality services during the acute phase following a violent incident is often critical to minimizing long-term suffering. The best chance of preventing death and disability to a victim with severe injuries exists when emergency medical services are provided within the first hour. Because victims and perpetrators with moderate to severe injuries are most likely to seek medical care in the acute phase after a violent incident, health workers have a window of opportunity to provide individuals with information on (and referral to) psychosocial services. From a legal perspective, prompt and effective services in the acute phase can be critical for initiating the legal process and for evidence collection (the chance of recovering admissible evidence is greatest within 72 hours post-assault).

With the exception of emergency medical services that health workers are obliged to provide even if an individual is unable to consent (for example life-saving procedures on an unconscious patient), informed consent is an essential feature of all services to victims of violence. When someone suffers an act of violence, they have often experienced feelings of helplessness and lack of control of the situation. It is therefore important to restore control to them during service delivery. Patients should not be forced into any procedure or service (such as forensic examination, counselling or HIV testing) but should be given the opportunity to decide for themselves which services to utilize. The service provider should explain clearly, accurately and non-judgementally the purpose and implications of each procedure and service so that the individual can make an informed decision about their care.

Forensic services

Victims of violence have a right to redress through criminal justice channels, yet because of the numerous barriers to reporting, investigating and prosecuting an assault case, especially a sexual assault case, comparatively few cases reach a courtroom and even fewer result in conviction – even in countries with well-functioning criminal justice systems and strong forensic services. As a result, many victims of violence are subjected to invasive forensic examination procedures without gaining any real benefit from the evidence collected. Governments have a responsibility to make sure that forensic services enhance the ability of individuals to pursue their case in court without inflicting further harm. Forensic evidence must be collected in a systematic and sensitive manner, handled and stored properly, and documented and reported completely and objectively.

Investment in forensic services should not be strengthened at the expense of general improvements to emergency medical services and trauma care. There are, however, steps policy-makers can take to ensure that forensic services meet victims' needs vis-à-vis the criminal justice system without prioritizing evidence collection above the medical, psychological and social needs of the victim (**BOX TEN**):

- implement minimum standards for forensic evidence collection that specify what evidence to gather and the proper collection techniques and indicate which persons are qualified to conduct a forensic examination and give evidence in court;
- institute mechanisms that ensure the proper training of health workers responsible for conducting forensic examinations, including training on report preparation and court appearances;
- allow victims of violence to make the decision whether or not to undergo a forensic examination, to file a complaint and to bring charges – access to forensic services should not be contingent upon an individual's intent to report the crime;
- coordinate services so that the number of interviews is minimized and multiple examinations (i.e. separate forensic and medical evaluations) are avoided;
- Make sure forensic examiners are trained and prepared to address the non-forensic service needs of the patients they see, providing direct care and referrals as needed.

BOX TEN

Removing barriers to medico-legal care

Linking forensic services with police involvement can create a barrier to access to medico-legal services because many victims of violence are reluctant to involve the police out of fear of the consequences to themselves and, sometimes, to the assailant. In Germany, forensic medicine specialists have long been responsible for examining injured assault victims in connection with legal procedures. However, these examinations have been rare and usually have been performed only with a mandate from a public prosecutor or the police. In an effort to remove barriers to these services, forensic physicians in Hamburg have established a voluntary practice model for the examination and counselling of patients who have been physically and sexually abused.

The Hamburg Medico-Legal Competence Centre, a joint initiative between the Institute of Forensic Medicine in Hamburg and the University Hospital Hamburg-Eppendorf, was designed to provide forensic and medical services to victims of violence without requiring them to involve the police or make an official complaint. At the Competence Centre, trained professionals are available to Hamburg residents 24 hours a day, seven days a week to collect and properly preserve forensic evidence, including documentation of physical injury suffered as a result of a violent act. When individuals choose not to report an incident to the public authorities, both the forensic documentation of their injuries as well as the biological evidence taken are subject to the confidentiality of medical records. Although the medical provider discusses the possibility of making an official police complaint, the decision lies solely with the injured person. Biological evidence is stored on-site for two years and made available should the individual choose to make an official complaint within that period.

In addition to the forensic examination, patients at the Competence Centre receive medical care in conjunction with other clinics and departments at the University Clinic Hamburg-Eppendorf and have access to on-site psychological counselling. The Competence Centre also works in collaboration with the Hamburg police.

Strengthening support and care services for victims as part of primary prevention

Victim support and care services can also contribute to reducing the occurrence of new acts of violence. Violence within families and other intimate relationships is often repetitive and can persist for long periods. In many cases of youth and hate violence, retaliation against prior acts of violence is an important motive, while children may learn to engage in violent behaviour as a result of observing such behaviour in older individuals. When the injuries or other manifestations of violence are noticed (for example by health or school officials) an opportunity to prevent future events is presented. Several strategic approaches for harnessing the prevention potential of these and other such opportunities have now emerged, and form an important part of violence prevention planning.

- **Engaging the health sector in violence prevention** As noted in the **Introduction** to this guide, considerably more cases of interpersonal violence come to the attention of health-care providers than to the police. However, the potential role of health-care providers in primary prevention efforts is often not widely understood or embraced, and there are many institutional and educational barriers which can limit their effectiveness. Programmes to educate health-care providers are an essential first step in violence prevention in this area, and a variety of initiatives are now under way around the world. Screening programmes to identify victims of intimate-partner violence, child maltreatment, sexual violence, or elder abuse are also being used in many emergency departments, doctors' offices, and clinical settings, although the effectiveness of these interventions in reducing subsequent violence is not well understood (**BOX ELEVEN**). Despite the limited understanding of the effectiveness of various strategies for engaging the health-care sector in violence prevention, physicians and other health professionals should be viewed as key gatekeepers in efforts to monitor, identify, treat and intervene in cases of interpersonal violence, and activities in this area should be considered important components of comprehensive violence prevention efforts, as they may reduce the likelihood of repeat victimization or perpetration in the future.

- **Intervening with victims of child maltreatment** The health and social consequences of violence are much broader than death and injury and include very serious harm to the physical and mental health and development of victims, particularly children. Studies indicate that exposure to maltreatment and other forms of violence during childhood is associated with risk factors and risk-taking behaviours later in life such as violent victimization and perpetration, depression, smoking, obesity, high-risk sexual behaviours, unintended pregnancy, alcohol and drug use. Such risk factors and behaviours then lead directly to some of the leading causes of death, disease and disability, namely heart disease, cancer, suicide and sexually transmitted diseases. Child maltreatment therefore contributes to a broad range of costly adverse health outcomes – both to the child and to society – over the course of a victim's life, and therapeutic interventions to intervene and mediate these outcomes should be considered important components of prevention efforts. Although scientific evidence of the overall benefits of therapeutic approaches has not yet been systematically collected, research is now beginning to suggest that such interventions can improve the mental health of victims.

BOX ELEVEN

Health sector identification and care for women suffering intimate partner violence

Much recent debate concerns whether, when and how to "screen" women for gender-based violence, in particular for intimate partner violence. Some professional organizations in the United States and the United Kingdom (such as the American Medical Association and the American and Royal Colleges of Obstetricians-Gynaecologists and Nurse Midwives) have urged health professionals to screen women routinely for gender-based violence. In addition, women's health and violence prevention advocates (such as the Family Violence Prevention Fund) cite experiential evidence to urge health practitioners to continue screening to enhance health-care responses and help women access available services. Still others advocate for asking women only when violence is suspected or where it can help make a diagnosis.

Yet recent statements from some national bodies (for example, the United States Preventive Services Task Force and the United Kingdom National Screening Committee) make no recommendations for or against routine screening for intimate partner violence, citing lack of evidence in support of either decision. The debate is likely to continue until the effectiveness, and the potential harm and benefits, of screening interventions are rigorously evaluated. The development of this evidence base is crucial to determining the most effective, safe and reliable way that the health sector can identify and support women who suffer from violence and its consequences.

There is agreement, however, that screening for violence should not put women at additional risk. While the health-care provider can play an important role in identifying women who suffer from violence and connecting them with appropriate services, the screening process must protect the privacy and confidentiality of the woman and be conducted in a safe and non-judgemental way. Research has shown that women want health-care providers to listen fairly to their experiences and to respect their control over decisions about their living arrangements and relationships. Health-care providers must respect a woman's autonomy and decision-making while assisting her to access the services she seeks.

Health-care providers often find it difficult to ask women about violence. They may feel that it is not part of their mandate; that they lack the training and skills to do it properly; that they have no time; or may even fear for their own safety. Training can be an effective tool to assist providers in overcoming barriers to screening, and should provide the necessary skills for effective screening and response, while also addressing underlying attitudes. Continuous, sustained support and supervision of providers complements training and is important for any screening programme.

When violence is identified, the health-care provider should respond to the needs of the individual woman, which may range from emotional support, to information about existing support services, to referral to these services (for example, emergency housing, legal remedies, counselling), and may include risk assessment and safety planning. Appropriate documentation and record-keeping that respects the privacy and confidentiality of the woman is also important. Health-service providers should network with other services in both the formal and informal sectors and create a directory of available services to facilitate appropriate referrals and follow-up.

5.2 Policy issues

Policies relevant to the provision of victim support and care services include those which relate to the availability of emergency medical services, to investigative procedures in cases of criminal assault, to the structure of forensic services, and to the response to gender-based and other forms of interpersonal violence.

Such services are affected by policy decisions in sectors as diverse as health, justice and social welfare, and are increasingly influenced by the working practices and programmes of civil society and for-profit groups that provide services. In many contexts it will not be possible to achieve a comprehensive and integrated victim-services policy, but the coordination of policy development between the different sectors that interact with victims of violence is a reasonable policy strategy for strengthening victim services. To promote this, it is necessary to determine which sectors are responsible for victim services, and the level (national, provincial or municipal) at which the policies that determine these services are set.

It is equally important to identify the institutional policies guiding service provision to victims of violence, for example in hospitals, specialized medical and forensic services, police stations, and counselling centres. As in other areas of activity, policies for victim services are only effective when those responsible for their implementation are aware of their existence and work consistently in accordance with them.

Other policy areas that may not seem directly related might still play a significant role in shaping the range and quality of services available to victims of violence. These areas include abortion; HIV/AIDS prevention; access to HIV/AIDS counselling, testing and treatment; treatment for drug and alcohol abuse; educational and literacy levels of workers; working conditions of service providers; and the general structure of services in terms of their public or private provision, available aid, or fees required.

Some policies may lead unintentionally to adverse effects on victims of violence, particularly those resulting in secondary victimization. This can occur for example where victims of sexual violence are required to undergo separate (and therefore repeated) anogenital examinations for medical and forensic purposes, or to relate the history of the attack multiple times to different people. Some policies may also discourage victims from seeking care (for example where an official complaint is required to access medico-legal services) or may discourage victims from disclosing abuse or assault (for example where mandatory reporting stipulations exist).

5.3 Action Steps in strengthening victim support and care services

There are four practical recommendations related to the strengthening of services for victims of violence:

5.1 Advocate for improvements in the quality of services
5.2 Conduct a policy audit and a situational analysis
5.3 Improve emergency medical services and trauma care
5.4 Involve the community in the design of specialized services.

RESOURCE BOX FIVE

Technical guidelines and other resources for strengthening victim support and care services

- World Health Organization. *Surgical Care at the District Hospital*. Geneva, World Health Organization, 2003. http://www.who.int/violence_injury_prevention/publications
- Mock CN, et.al. *Guidelines for essential trauma care*. Geneva, World Health Organization, 2004. http://www.who.int/violence_injury_prevention/publications
- World Health Organization. *Guidelines for medico-legal care for victims of sexual violence*. Geneva, World Health Organization, 2004. http://www.who.int/violence_injury_prevention/publications
- World Medical Association. Statement on violence and health, adopted by the World Medical Association, Helsinki 2003. http://www.wma.net/e/policy/v1.htm

ACTION STEP 5.1

Advocate for improvements in the quality of services

Advocacy for the provision of quality services to victims of violence should take into account all levels of need (for example, medical, psychological, social, legal) and aim to promote a balanced system of provision founded on evidence-based services and interventions. This requires advocacy at the national, local and institutional level, and should include advocacy efforts with private practitioners and nongovernmental organizations as they too are likely to interact with the victims of violence. If no evidence exists to show that particular services, strategies or interventions are either effective or ineffective, planners should proceed carefully and base the planning process on expert consensus and operational research. Advocacy messages should include government responsibility to ensure adequate resource allocation for victim support and care services and ongoing research to facilitate improvements.

The health sector must advocate not only for improved health services for victims of violence, but also for improved psychological, social and legal services and more effective linkages between these services to make sure the full range of services required by victims is addressed. Where there are adequate services and support available, governments should disseminate messages that convey the importance of seeking care as quickly as possible following an act of violence.

ACTION STEP 5.2

Conduct a policy audit and a situational analysis

Policies relevant to victim services at the appropriate level (national, local or institutional) should be identified and analysed. Findings should then be disseminated in a report on the strengths and gaps in policy, and on the steps needed to improve the policies that govern or affect victim services.

A situational analysis describing available short-term emergency services, both public and private, is important for determining what services exists, how they are organized, and how accessible they are. Services should be examined in all the associated sectors (for example, medical, forensic, social, legal) and case studies prepared to show how they are organized and run. A map showing hospitals, clinics and specialized facilities (such as crisis centres, district surgeons and police stations) as well as population density should be produced. However, when assessing population access to services, it is crucial to consider more than just geographical distribution and population density – financial, transportation, time, cultural and other barriers must all be considered when judging the accessibility of services.

ACTION STEP 5.3

Improve emergency medical services and trauma care

Unless death occurs immediately, the outcome of an injury resulting from interpersonal violence depends not only upon its severity, but also on the speed and appropriateness of treatment. The establishment of trauma systems designed to treat and manage injured victims more efficiently and effectively (including those injured by violence) is therefore an important factor in reducing the overall health burden of violence. Acute treatment of the injured requires a special approach, and research has suggested that reductions in the lethality of criminal assault in the United States is in part explained by the application of developments in medical technology and medical support services. General improvements in emergency medical services and trauma care will benefit all injury victims including victims of violence (**BOX TWELVE**). Advocates should therefore promote the provision and proper functioning of these services, especially as they are often the entry point to the health system for victims of violence.

General emergency services staff need the skills to recognize and diagnose violence, understand its consequences and manage these appropriately. This will include skills in addressing psychological trauma as well as physical trauma, and skills to detect violence-related injuries without stigmatizing all those who present with "suspicious" injuries. The proper training of staff is key to ensuring that these skills are in place.

In reality, most planners and policy-makers will not be in a position to implement all the necessary measures at one time. A number of important components in efforts to improve emergency services for victims of violence, and to add value to services without excessive cost, can therefore be prioritized as follows:

- Establish an interdisciplinary team to conduct injury-severity scoring on deceased victims to reveal any excess mortality due to inadequate emergency services and to indicate in what ways services need to be strengthened.

- Initiate a meeting of stakeholders from relevant sectors to discuss coordinated policy development for strengthening victim services.
- Institute first responder and emergency life-support training for those most likely to be exposed to situations where violence has just occurred (for example, police officers) and advocate for the consistent supply of materials and equipment to enable those trained to work effectively.
- Train police officers and health workers in gender and violence issues to increase the sensitivity and effectiveness of their response to female victims of violence – female victims of violence are often re-victimized by service providers, especially those who have a low opinion of women in general, blame them for the violence, and question their account of the incident.
- Allow access to medical, forensic and other services regardless of whether or not the victim has made (or intends to make) a formal complaint about the crime.
- Where appropriate, incorporate violence issues into the curriculum of medical, nursing and public health schools, as well as in police academies.
- Offer short-course in-service training on violence to those who have frequent contact with victims in the course of their professional duties.

BOX TWELVE

Trauma mortality patterns in different economic settings – implications for global trauma system development

Although organized trauma-care systems have significantly decreased trauma mortality in developed countries (particularly in the United States) their design has not been well addressed in developing nations. To determine which aspects of trauma systems are in greatest need of improvement in such settings a comparison was made of all cases of seriously injured (Injury Severity Score > or = 9 or dead) non-transferred adults admitted over a 1-year period in the following three cities:

- Kumasi, Ghana – low-income setting; gross national product (GNP) per capita US$ 310; no emergency medical service (EMS)
- Monterrey, Mexico – middle-income setting; GNP US$ 3900; basic EMS
- Seattle, Washington, United States – high-income setting; GNP US$ 25 000; advanced EMS.

Each city had one main trauma hospital, from which data were obtained. Annual budgets per bed were: Kumasi, US$ 4100; Monterrey, US$ 68 000; and Seattle US$ 606 000. Data on pre-hospital deaths were obtained from vital statistics registries in Monterrey and Seattle, and by an epidemiologic survey in Kumasi.

Although mean age (34 years) and injury mechanisms (79% blunt) were similar in all locations, mortality rates declined with increased economic level. In Kumasi, 63% of all seriously injured people died, while in Monterrey and Seattle the corresponding figures were 55% and 35% respectively. The decline was primarily due to decreases in pre-hospital deaths. In Kumasi, 51% of all those seriously injured died in the field; in Monterrey this was 40%; and in Seattle 21%. The mean pre-hospital period also declined progressively with the longest delays observed for trauma patients in Kumasi (102 ± 126 minutes) followed by Monterrey (73 ± 38 minutes) then Seattle (31 ± 10 minutes). The percentage of trauma patients dying in the emergency room was higher for Monterrey (11%) than for either Kumasi (3%) or Seattle (6%).

The majority of deaths occurred in the pre-hospital setting, indicating the importance of injury prevention across all economic settings. Additional efforts for trauma care improvement in both low-income and middle-income developing nations should focus on pre-hospital and emergency room care. Improved emergency room care is especially important in middle-income settings where a basic EMS has been established.

ACTION STEP 5.4

Involve the community in the design of specialized services

The involvement of multiple community stakeholders is a central principle of successful health-service planning and is no less important in the context of planning specialized services for victims of violence. The implications of violence and social consequences of victimization and perpetration may differ from community to community, between various groups in the same community, and between men and women. Social norms relating to violence and health care will affect the care-seeking behaviour of victims in

the community, and these must be accounted for in the planning and implementation of services. Special attention should be given to planning services for people who face intense social stigma as victims of particular types of violence to ensure that they are not further stigmatized while (or because of) accessing the services.

Consulting victim-support and other nongovernmental organizations during the planning process is a crucial factor in ensuring the provision of "culturally relevant" services. Similarly, conducting community outreach and holding focus-group sessions with community members and potential service users (taking particular care to include groups that are marginalized within the community and/or experience a high incidence of violence) will help to develop a better understanding of cultural norms regarding different types of violence and the seeking of care after incidents, and will help to identify any barriers to accessing services. Communities should also be involved in planning and conducting evaluations of services.

PART 6

Bringing it all together – developing a national plan of action

6.1 Conceptual aspects

A national plan of action for preventing interpersonal violence and improving victim support and care is the blueprint that provides the different sectors involved with a set of common goals, a shared time frame, a strategy for coordinating activities, and a framework for evaluation. Such a national plan is therefore the key to organizing national and community-level interventions that involve more than one objective and which depend upon the input of participants from different sectors.

In most countries, national, provincial and municipal health authorities carry the main responsibility for disease prevention and health promotion. As a result, they are likely to have the human resources and technical skills required to coordinate the multi-sectoral violence prevention programmes and victim support and care services advocated in this guide. It is therefore highly desirable that wherever possible the health ministry should take the lead in developing a national plan of action, while at the same time facilitating multi-sectoral involvement with the other stakeholders identified earlier in the **Introduction**. When formulating a national plan of action for the prevention of interpersonal violence it is useful to think in terms of both the *content* of the plan and its *structure*.

Content

The content of a national plan of action refers to the precise activity areas and topics addressed and this will necessarily reflect local realities, as well as developments in the understanding and prevention of interpersonal violence. It is, however, useful to consider the five recommendations of the *World report on violence and health* covered in this guide as the main potential activity areas:

- Increasing the capacity for collecting data on violence (**Part 1**)
- Researching violence – its causes, consequences and prevention (**Part 2**)
- Promoting the primary prevention of interpersonal violence (**Part 3**)
- Promoting social and gender equality and equity to prevent violence (**Part 4**)
- Strengthening support and care services for victims (**Part 5**).

A plan of action should also specify goals for each of the activity areas above, objectives and strategies for achieving them, and measurable progress indicators. This in turn requires the obtaining of baseline measurements, both of the problem and of inputs to deal with it, while setting out a clear time frame for implementation and deadlines for the completion of component activities.

Any effective national plan of action is likely to be multi-sectoral; developing inter-sectoral leadership in violence prevention across all levels of the programme is therefore an explicit recommendation of the *World report on violence and health*. To facilitate efficient and meaningful collaboration, the plan of action must clearly identify the roles and responsibilities of each of the different sectors and disciplines involved in addressing each of these activity areas. Furthermore, national plans of action should explicitly incorporate goals and objectives pertaining specifically to inter-sectoral collaboration and leadership. For instance, an inter-ministerial task force for the prevention of violence could be formally established through an agreement that obliges different ministries to collaborate in the prevention of interpersonal violence under the overall leadership of the ministry of health.

While national initiatives are vital for the setting of goals, standards and overall policy direction, the actual delivery of preventive interventions and victim support and care services is most often carried out by provincial and municipal government, and increasingly by nongovernmental agencies. The plan of action should therefore make provision for both national and local-level prevention and victim care activities, and might include, for example, the establishment by provincial authorities of a specified

number of municipal-level violence prevention programmes within the towns and cities under their jurisdiction.

Within each activity area, mechanisms for promoting internal advocacy campaigns and for receiving and responding to advocacy input from civil society groups may be detailed (see **Action Step 3.4**). In a number of countries the national violence prevention agenda has been significantly advanced by input from advocacy groups, which are routinely involved in making the case for violence prevention before national and provincial parliamentary decision-making bodies. Each activity area might also include procedures for identifying stakeholders at the national, regional and possibly the global level, and for specifying a core set of messages and information to be conveyed. Examples of stakeholders include national media, prevention partners in other government departments and outside government, United Nations agencies and donor countries.

Structure

Structure refers to the way in which the national plan is organized, and how each of the main content areas is subdivided into smaller areas. A national plan of action should be written and structured in such a way that participants from different sectors can easily understand it. It should also include a concise summary version, and be available in tabular form to facilitate presentation.

As shown in **FIGURE FOUR**, a standard plan of action consists of *Activity areas*, each with a brief accompanying *Problem statement* that captures the challenges that must be addressed. Each activity area is then divided into one or more *Goals*. Each goal is in turn split into one or more *Objectives*, and for each objective the *Activity*, *Performance indicators*, *Human resources*, *Cost* and *Time frame* are then specified. **TABLE FOUR** provides a worked example for the activity area labelled "Developing inter-sectoral leadership in violence prevention".

To ensure that a national plan of action contributes to improved coherence and coordination between different participating groups and disciplines, it is important to build it around a limited number of activity areas. One option is to use the country-level recommendations of the *World report on violence and health* detailed in this guide as the main activity areas.

FIGURE FOUR Structure of a national plan of action for the prevention of violence

ACTIVITY AREA 1: PROBLEM STATEMENT		
GOAL 1.1	Objective 1.11	➤ Activity ➤ Performance indicators ➤ Human resources ➤ Costs ➤ Time frame
	Objective 1.12	➤ Activity ➤ Performance indicators ➤ Human resources ➤ Costs ➤ Time frame
GOAL 1.2	Objective 1.21	➤ Activity ➤ Performance indicators ➤ Human resources ➤ Costs ➤ Time frame

TABLE FOUR Example of summary national plan of action items in the activity area "Developing inter-sectoral leadership in violence prevention "

Problem statement
No single ministry, department or individual is responsible for the prevention of violence. Consequently, there is low or no awareness of the possibility of violence prevention, and no mechanisms by which interpersonal violence and its prevention can be approached in a unified way that combines the inputs of many different ministries and nongovernmental stakeholders.

GOALS	OBJECTIVES	ACTIVITY	PERFORMANCE INDICATORS	HUMAN RESOURCES	COST	TIME FRAME
Create and staff the position of health ministry focal point for the prevention of violence.	Identify a departmental base for the focal point, create the position, and prepare terms of reference for the position.	Prepare a proposal and budget for the new position, plus a job description.	Post established, job description and terms of reference available.	Leadership by senior health ministry official, personnel officer, consultant.	Salary and benefits as per health ministry scales and allowances.	Six months from programme commencement.
	Recruit the focal point.	Advertise the position, interview candidates and select incumbent.	Focal point commences employment.	Health ministry personnel officers plus inter-ministerial selection committee.	Costs of advertising and recruitment.	Nine months from programme commencement.
Establish an inter-sectoral advisory committee	Obtain high-level political approval and mandate to convene committee and establish a meeting timetable.	Prepare a proposal for forming such a committee and lobby for its support and approval.	Mandate received; meeting timetable drafted.	Health ministry focal point.	Staff time.	14 months from programme commencement.
	Recruit ministries and agencies to be involved and appropriate individuals within them.	Meet with relevant ministries and directors, present committee vision, and define the required input and level of decision-making required by members.	Formal establishment of committee through an inter-ministerial agreement; inter-sectoral advisory committee completes first series of meetings.	Health ministry focal point.	Costs of travel to meetings by committee members, costs of hosting meetings.	20 months from programme commencement.

6.2 Policy issues

A national plan of action is a strategic document that provides a foundation for the subsequent and ongoing development of formal policy and legislative instruments; resource mobilization and allocation; programme design and implementation; and training and capacity development.

6.3 Action Steps in developing a national plan of action

No matter which stage a country has reached on the violence prevention path, a national plan of action can be developed. The primary resource requirement is an individual within government (preferably within the health ministry) or a government-contracted consultant to implement the following six proposed **Action Steps**:

6.1 Identify and consult key stakeholders
6.2 Draft a national situational analysis on interpersonal violence and health
6.3 Convene a national consultative conference
6.4 Revise and finalize the plan of action
6.5 Obtain endorsement for the plan of action
6.6 Implement, monitor and report on progress.

ACTION STEP 6.1

Identify and consult key stakeholders

Consultation with government and nongovernmental stakeholders on the prevention of interpersonal violence and the provision of support and care services to those affected is critical in ensuring ownership of the plan of action. These stakeholders (listed in **Introduction**) will represent many sectors and disciplines. Some may have little experience of working with one another and little insight into how the other sectors understand and respond to the problem of interpersonal violence.

In identifying and involving stakeholders the aim should be to achieve sufficient consensus for the programme to begin. Trying to involve every agency that seems relevant is likely to prove too cumbersome, and initiating too wide-ranging a consultative process is likely to get out of hand and ultimately obstruct rather than enable the process. Conversely, failure to consult key groups could mean that they will reject the proposed programme and prevent its implementation. Deciding on the groups that should be consulted is therefore a crucial issue, and one that will depend upon realities at the local and national level at which the plan of action is being developed.

At the outset of any inter-sectoral violence prevention work, individuals working in different sectors may show a tendency to restrict themselves in their thinking on the issue to the "comfort zone" of their sectoral competency. For example, psychologists may see their role as counselling victims of violence; the police may consider that violence is best prevented by allocating more resources for the apprehension and punishment of criminals; while medical professionals may be preoccupied with trauma-care issues.

Achieving success in violence prevention requires complementing these competence-based perspectives and skills with a focus on key priority problems rather than core competencies. For violence prevention, this means that individuals must be persuaded to move beyond their comfort zones and set aside all the things they disagree about for the one thing that they do agree upon, namely that people should not be killed and harmed by other people.

Achieving such agreement sets the scene for involving people in a neutral, analytical, action-oriented exercise where personal and organizational agendas are left at the door and there is acknowledgement that no single agency or group can solve the problem of violence on its own.

Consultation with the agencies and individuals identified should be structured around **Action Step 6.2** (the compiling of a national situational analysis on interpersonal violence and health) and the obtaining of information relevant to the main activity areas of the national plan of action. This should include an assessment of the readiness of politicians to endorse a plan of action for violence prevention and the readiness of citizens to support such steps and lobby for increased investment in violence prevention.

ACTION STEP 6.2

Draft a national situational analysis on interpersonal violence and health

One prerequisite of systematic planning is a clear understanding of the problem of interpersonal violence, of current responses to it, and of anticipated responses by different stakeholders. Conducting a national situational analysis is one way of obtaining this information, and can help to create a common topic for inter-sectoral discussions on prevention and care services for victims. The situational analysis should be based on information already available (i.e. it should not involve the commissioning of new basic research), but should be more expansive than the initial profile of the problem as described in **Part 1**. It should provide a snapshot of what is known about:

- the size and nature of the problem
- the root causes that underlie the problem
- what is being done about it by the various sectors
- what is being achieved by the different sectors
- what roles the various sectors could and should be playing
- what the different sectors believe should be done next.

Because the available information will have been produced for many different reasons, it is likely that the situational analysis will reveal discrepancies between different information sources covering the same issue, or for some issues may conclude that there is no information available. It is also likely to highlight that little or no coordination exists between different departments and different sectors owing to the absence of violence prevention leadership and a clearly defined centre for this.

Such discrepancies and information gaps are powerful incentives for cross-boundary conversations on the problem of interpersonal violence and what to do to prevent it. Discrepancies should therefore be explicitly acknowledged as important findings of the report, rather than dismissed in any way. Discrepancies in statistics and divergences in the "facts" of who is doing what and with what effects provide powerful arguments for investing the resources needed to employ a dedicated violence prevention coordinator and to create a national centre for the prevention of violence. Identifying discrepancies and information gaps will also help to identify priority areas for data collection and research.

ACTION STEP 6.3

Convene a national consultative conference

The aim of a national consultative conference is to reach consensus around the content and structure of the national plan of action by allowing all stakeholders the opportunity to comment upon a draft outline. The programme for such a conference should commence with a national overview of interpersonal violence and health, and should include an opportunity for group discussions around each of the main proposed activity points in the plan. Planning should anticipate tensions between representatives of different sectors, and must pay special attention to strategies for overcoming them.

ACTION STEP 6.4

Revise and finalize the plan of action

Once the draft plan of action is ready, it should be circulated among key stakeholders for one more round of comments aimed at ensuring that the plan adequately reflects the inputs received during consultation. It should then be finalized and published in an accessible yet authoritative format.

ACTION STEP 6.5

Obtain endorsement for the plan of action

Endorsement of the plan of action should include formal letters of agreement to its content and commitment to its implementation from all government partners in the initiative, and where appropriate from statutory bodies, international agencies, NGOs and other agencies that may be centrally involved in the work. In addition, informal endorsement should be obtained from the broader community of violence prevention practitioners and the citizen groups that are the intended beneficiaries.

ACTION STEP 6.6

Implement, monitor and report on progress

Implementation of the plan of action should follow the timetable set out for each activity area and where relevant should make use of the **Action Steps** set out in **Parts 1–5** of this document. Monitoring implementation of the national plan of action and reporting on progress should be conducted with reference to the baseline information, indicators and time frames specified for each objective within the plan. It is helpful in this regard to specify when a follow-up report should be prepared. In most instances this follow-up report should be timed to appear no more than two to four years after commencing implementation of the national plan of action.

Conclusion

Each of the six parts of this guide corresponds to one of the six country-level recommendations of the *World report on violence and health* and associated World Health Assembly Resolution calling on WHO Member Sates to implement these recommendations (see **Introduction**). Each part has provided a set of suggestions for activities in the areas of policy formulation, systems development and programme implementation that if acted upon will assist countries in following these recommendations and thereby help to prevent interpersonal violence and improve care services for victims.

A central message of the guide is that both multi-sectoral involvement and clear leadership are essential to the success of national, municipal and community-based efforts to prevent violence. The health ministry, because it bears the major burden of caring for victims of violence and is chiefly responsible for the prevention of disease and health promotion, is strongly recommended as the lead agency. To enable inter-ministerial and multi-sectoral involvement, the establishment of formal mechanisms that clearly specify the roles and functions of the participants is also recommended.

As with every new public health challenge, initial attempts to implement the suggestions in this guideline are likely to be resisted on the grounds that they will cost too much and cannot be contemplated in the face of more important health priorities such as HIV/AIDS, malaria or tuberculosis. However, even if the resources for achieving certain aspects of the recommendations are lacking, the information contained in this guide will still be useful for planning purposes. Since plans usually precede actions (and are often used to generate the resources needed to implement actions), this guide will be of use even in areas where violence prevention resources are currently scarce.

In addition to the positive benefits that effective violence prevention can have for the quality of individual, family, community and social life, the potential financial savings are also enormous. The costs of treating the sometimes lifelong consequences of violence, to say nothing of the indirect costs of lost productivity, are staggering. By establishing effective prevention measures along the lines suggested in this guide, many aspects of life could be improved for populations with the money currently spent on treating the consequences of interpersonal violence. By improving care services for those who do become victims of violence, much can be done to minimize the severity of their physical and psychological injuries and increase the likelihood that they can return to productive and fulfilling lives as true survivors.

> Violence leaves no continent, no country and few communities untouched. Although it appears everywhere, violence is not an inevitable part of the human condition, nor is it an intractable problem of "modern life" that cannot be overcome by human determination and ingenuity.
>
> *World report on violence and health*

ANNEX

Summarized Action Steps and Resource Boxes

PART 1: ACTION STEPS TO INCREASE DATA-COLLECTION CAPACITY

RESOURCE BOX ONE 18

Technical guidelines and other resources for implementing Action Steps for data collection

- WHO Collaborating Centre on Injury Surveillance. *International classification for external causes of injuries*. Amsterdam, Consumer Safety Institute, 2001. http://www.iceci.org
- *International Statistical Classification of Diseases and Related Health Problems*. 1989, Revision. Geneva, World Health Organization, 1992.http://www.who.int/whosis/icd10/
- *Injury Surveillance Guidelines*. Geneva, World Health Organization, 2001. http://www.who.int/violence_injury_prevention/publications
- Sethi D, et.al., eds., *Guidelines for conducting community surveys on injuries and violence*. Geneva, World Health Organization, 2004. http://www.who.int/violence_injury_prevention/publications
- German RR et al. Updated guidelines for evaluating public health surveillance systems. Centers for Disease Control and Prevention, MMWR, July 27, 2001/50(RR13):1–35. http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5013al.htm
- Centers for Disease Control and Prevention, *Epi Info 2002*, revision 2 (shareware computer programme for public health surveillance). Atlanta, Centers for Disease Control, 2003. http://www.cdc.gov/epiinfo/

PART 2: ACTION STEPS FOR RESEARCHING VIOLENCE

RESOURCE BOX TWO 30

Technical guidelines and other resources for implementing Action Steps for researching violence

- Council for Health Research and Development (documents and information on country and international partners in Essential National Health Research). http://www.cohred.ch/
- Global Forum for Health Research (aims to focus research efforts on diseases representing the heaviest burden on the world's health and to facilitate collaboration between partners in both the public and private sectors). http://www.globalforumhealth.org/pages/index.asp

PART 3: ACTION STEPS IN PROMOTING PRIMARY PREVENTION

RESOURCE BOX THREE 44

Technical guidelines and other resources for implementing Action Steps in promotimng primary prevention

- Sethi D, et.al. *Handbook for the documentation of interpersonal violence prevention programmes*. Department of Injuries and Violence Prevention, World Health Organization, Geneva, 2004. http://www.who.int/violence_injury_prevention/publications
- United States Centers for Disease Control Evaluation Working Group (includes step-by-step manuals on how to carry out evaluation, links to other resources, journals and on-line publications). http://www.cdc.gov/eval/resources.htm
- Injury Prevention Web (includes over 1400 links to violence and injury prevention web sites worldwide). http://www.injuryprevention.org

PART 4: ACTION STEPS IN PROMOTING SOCIAL AND GENDER EQUALITY AND EQUITY

RESOURCE BOX FOUR 53

Technical guidelines and other resources for implementing Action Steps for promoting social and gender equality and equity

- United Nations Department of Economic and Social Affairs, Division for Social Policy. http://www.un.org/esa/socdev/
- International Covenant on Economic, Social and Cultural Rights (1966). http://www.unhchr.ch/html/menu3/b/a_cescr.htm
- International Covenant on Civil and Political Rights (1966). http://www.unhchr.ch/html/menu3/b/a_ccpr.htm
- International Convention on the Elimination of All Forms of Racial Discrimination (1965). http://www.unhchr.ch/html/menu3/b/d_icerd.htm
- Convention on the Elimination of All Forms of Discrimination Against Women (1979). http://www.unhchr.ch/html/menu3/b/e1cedaw.htm
- Beijing Declaration and Platform for Action. United Nations (1995) Platform for Action in *Report of the Fourth World Conference on Women*, Beijing, 4–15 September 1995 (United Nations publication, Sales No. E.96.IV.13), chap. I, resolution 1, annex II. http://www.un.org/womenwatch/daw/followup/beijing%2B5.htm
- Landsberg-Lewis I, ed. (1998). *Bringing equality home: the convention on the elimination of all forms of discrimination against women*. New York, NY. UNIFEM. www.unifem.org
- Office of the Special Adviser on Gender Issues and Advancement of Women (2002) *Gender mainstreaming: an overview*. New York, NY. United Nations Department of Economic and Social Affairs. http://www.un.org/womenwatch/osagi/statementsandpapers.htm
- Spindel C, Levy E, Connor M (2000). *With an end in sight: strategies from the UNIFEM trust fund to eliminate violence against women*. New York, NY. UNIFEM. www.unifem.org

PART 5: ACTION STEPS IN STRENGTHENING VICTIM SUPPORT AND CARE SERVICES

RESOURCE BOX FIVE

Technical guidelines and other resources for strengthening victim support and care services

- World Health Organization. *Surgical Care at the District Hospital*. Geneva, World Health Organization, 2003. http://www.who.int/violence_injury_ prevention/publications
- Mock CN, et.al. *Guidelines for essential trauma care*. Geneva, World Health Organization, 2004. http://www.who.int/violence_injury_ prevention/publications
- World Health Organization. *Guidelines for medico-legal care for victims of sexual violence*. Geneva, World Health Organization, 2004. http://www.who.int/violence_injury_ prevention/publications
- World Medical Association. Statement on violence and health, adopted by the World Medical Association, Helsinki 2003. http://www.wma.net/e/policy/v1.htm

PART 6: ACTION STEPS IN DEVELOPING A NATIONAL PLAN OF ACTION

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